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THE NATURAL MANAGERS?

**A Study of the evolving role
of
NHS doctors in management**

Francis Joseph Wall

1999

**A thesis submitted for the partial award of PhD
of the
University of Durham
Department of Sociology and Social Policy**

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ABSTRACT

The Natural Managers?

A Study of the evolving role of
NHS doctors in management

Francis Joseph Wall
Degree of Doctor of Philosophy
1999

This study traces the evolving role of NHS doctors in management, from the early years of informal, but highly influential involvement, to the formalised and accountable positions they now occupy in management. The study attempts to assess whether doctors are "the natural managers" of the NHS and, if so, the implications of this. The associated argument, which is pursued throughout the study, is that power and authority need to be brought together in order for management to be effective and argues that the involvement of doctors in management is the only realistic way to bring this about.

A qualitative research approach has been used to explore through interviews, the views, opinions and experiences of 30 key informants, including Consultant Medical staff, (many of whom occupy Medical/Clinical Director positions), General Medical Practitioners, Chief Executives, senior NHS Executive and Health Authority officials, and other health professionals.

The study, which is mainly centred on the operational level in secondary care, concludes that the active, formal involvement of doctors in management does bring about the blend of power and authority which was previously missing, but no over-riding view was expressed by informants to suggest that this means doctors are "the natural managers." In order to make better use of clinical and other resources, a shared partnership in decision making at the top of the management structure between the senior doctor manager and the lay Chief Executive is required. More encouragement is needed to develop the present fragile role of doctors in management in order to secure the relatively untapped source of managerial power and authority which the involvement of doctors in management can bring about.

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My wife Anne, herself a NHS professional, read and commented on various draft copies of the thesis as it unfolded, and listened to a great deal more during this exercise. Without her support and forbearance it simply would not have happened.

F.J. Wall
October 1999

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INTRODUCTION

Roy Griffiths (later Sir Roy), who headed the NHS Management Inquiry Team which reported to the Secretary of State for Social Services on 6th October 1983, considered that "The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers" (Griffiths, 1983, pp18-19).

This study is intended to trace the history and the evolving role of doctors in management in the NHS up to late 1997, to try and assess how far doctors are "the natural managers" and, if so, what are the implications of this. The associated argument, which is pursued throughout the study, tests the idea that power and authority need to be brought together in order to be effective in shaping the NHS and that the active involvement of doctors in management is the only realistic way to bring this about.

In the first chapter, the research is explained together with details of the literature search and the research methods used for the fieldwork including the means of data analysis. A qualitative approach to the research allowed the study to explore a wealth of data from interviews with key informants currently employed in the NHS in hospitals and in other health care organisations.

In the second and third chapters, the government initiatives, reorganisations and reforms which have been a feature of the NHS throughout its fifty year history are examined. Attempts to try to encourage medical staff into management are included, such as the introduction of the Resource Management Initiative and the 1983 Griffiths Report, the latter of which was a watershed in managerial terms. The 1989 White Paper "Working for Patients" is also discussed in chapter three.

The fourth chapter explores the wider debate relating to power and authority and demonstrates how medical power and medical dominance gave consultant medical staff a disproportionate influence over the organisation and management of the health service from its inception. The chapter seeks to show how the divide between the power of the consultant and the authority of the lay manager has

weakened the thrust and direction of health services.

The main focus of this thesis is concentrated on doctors and management in services for the physically ill in secondary care. However, in chapter five, the radical changes in primary care, which have a direct and indirect bearing on the evolving role of NHS doctors in management in secondary care are discussed. The study examines these changes and the consequent emergence of the doctor manager GP in a practice environment which has changed dramatically in the past ten years. Discussion on these changes, is included, together with discussion on the changed relationship between consultant medical staff in secondary care and GPs.

In chapter six the role of the pre-Griffiths manager is explained, demonstrating how lay management lacked power and had what can only be described as weak authority (especially over medical staff), a position which contributed to the introduction of general management following the Griffiths Report. The dilemmas faced by doctors as they become involved in management are examined, including the question of rationing and their value position as doctors. These have often been perceived to conflict with the objectives of management. The statutory position of Medical Directors on the boards

of NHS Trusts is explained and the Clinical Directorate System, which many doctors favour as a way to become involved in management in secondary care, is examined.

In the next three chapters (chapters 7-9) fieldwork data from interviews with key informants are discussed, analysed and interpreted. As many of the first wave of doctors in management following the 1991 Reforms came to the end of their first contract period, it was an interesting time in 1996 to interview these "pioneer" Medical/Clinical Directors to elicit their views, opinions and experiences. Interview data from other health professionals, from academics and others in order to balance the data between clinicians and non clinicians are included in these chapters. Chapters nine and ten, as well as discussing and analysing fieldwork data also draw conclusions to my associated argument relating to the idea of the importance of power and authority being brought together and to my core research question of whether doctors are "the natural managers." The implications of the conclusion to this question are included in the final chapter.

CHAPTER ONE
THE RESEARCH, METHODS AND ANALYSIS

The seeds of research are often sown long before the opportunity arises for them to be nurtured into fruition. So it was for me. I can well remember, as a hospital manager in a District General Hospital in the early 1980s, seeing the Chief Officer of the Health Authority, the District General Manager, standing waiting in the corridor outside the Board Room where the Consultant Medical Advisory Committee was holding its monthly meeting, a meeting which would be taking decisions, both clinical and non clinical, which would have enormous resource implications for the Health Authority.

He had been "summoned" to attend this "high powered" meeting of Medical Consultants to answer questions on an agenda item. He would be invited in for that part of the meeting only, questioned, then thanked and asked to leave the meeting as it proceeded to the next item on the agenda.

The humiliation he felt at being "summoned", then made to wait until being called into the meeting, despite his position as the Chief Officer of the Health Authority, and then being asked to leave, was blatantly obvious as he fumed inwardly at being regarded once again as "below the salt."

It occurred to me as I observed this monthly ritual that herein lay one of the major problems that has dogged the National Health Service since its inception. Frequent reorganisations of the Health Service had attempted to find a managerial solution to its problems, not least the problems associated with making the best use of clinical and other resources, but these reorganisations had failed to recognise certain key elements, the difference between power and authority and the fact that one cannot be effective without the other.

The Chief Officer standing in the corridor had formal authority but not the power, hence his being summoned to such a meeting. The consultant medical staff had the power but not formal authority. It seemed to me, even at that time, that some system was needed to marry the elements of power and authority together. The lay General Manager could never acquire the power of the consultant since he was always, in an NHS based on a

medical model of health and health care, going to be heavily dependent on clinical advice and clinical knowledge and was realistically unlikely to become medically registered (although a few general managers did come - and do come - from a medical background), whilst the medical consultant on the other hand can, it has increasingly been argued, acquire, with training, the managerial skills necessary to hold positions of authority (there is of course no equivalent managerial registration).

I shall argue in this thesis that this split between power and authority, i.e. power in the hands of consultant medical staff, and authority in the hands of lay managers, weakens the thrust and direction of the organisation in trying to achieve its overall objectives of providing quality care for patients and making the best use of clinical and other resources.

Background

The role of NHS doctors in management has been evolving since the very beginning of the NHS. Indeed even before the "appointed day", 5th July 1948, when the historic announcement was made that the National Health Service Act 1946 had now become a reality, medical staff and their leaders were battling with politicians as to

what would be the position of doctors in this new National Health Service. It was only after considerable compromise by the government of the day, and on the understanding that clinical freedom and clinical autonomy would be maintained and protected, that doctors agreed to be part of this new health service (Levitt and Wall, 1992, pp10-11).

It follows that any study of the evolving role of NHS doctors in management must trace this evolution through the history of the National Health Service, stopping at certain times to dwell more on the developments of the time, the various reorganisations, major social policy changes that have impacted on the organisation and management of the health service, numerous financial crises and so on.

It is a fascinating history. It encompasses not only health issues, but social policy changes that have had a considerable impact on the organisation and management of the National Health Service over the years. For these reasons my research is an amalgam of the literature relating to the historic background of the National Health Service, together with fieldwork and data collection from discussions and interviews with present day medical clinicians and other health professionals. It

revolves around key players who are some of the most powerful, intelligent and articulate of all professionals and who are operating in one of the largest and most complex organisations in the world.

Research Questions

The core question for this thesis is that of whether doctors are "the natural managers". Are they the only group in the NHS who can acquire the blend of power and authority, which will be argued throughout this thesis to be essential in its organisation and management and to the more efficient use of clinical resources? Linked to this, is the question of what might be the implications of doctors as managers - for individual doctors, for patients and the treatment and care they receive, for the use of clinical resources, for government, for the medical profession as a whole, for lay managers, and for other groups of NHS workers?

In order to explore the proposition that power and authority needs to be together in the hands of consultant medical staff in order to facilitate the possibility of a more efficient use of clinical resources, a number of associated questions needed to be asked. I needed to explore the impacts of the major changes and reforms which have happened in the NHS. I wanted to ask if clinical and

non clinical managers see their key tasks as being similar and if it made any difference whether managers are doctors, lay managers or other health professionals? Was clinical knowledge an essential ingredient in the management of the NHS? Was clinical autonomy still intact? Had clinical audit the potential to reduce the autonomy of individual doctors whilst increasing the power of the group of doctors? Does the government want more doctors involved in management, and if so, why? Who holds the balance of power in the NHS? Is this changing? What are the impressions and experiences of the first generation of doctors to be involved in formal management in the "new" NHS of the 1990s?

As many Medical Directors and Clinical Directors are coming to the end of their first appointments as such, what are their views of these ways of involving doctors in management? Is the Clinical Directorate system a suitable system to harness the blend of power and authority? What other mechanisms have been or (could be) developed to bring doctors closer to management?

These and other associated questions, all relevant to my overall research questions, were included as part of my fieldwork research, which was conducted in 1996 (so prior to the election of the new Labour government in May 1997).

The purpose behind the range of questions asked of my respondents (which are outlined on my interview schedule, see Appendix I) was to try and build up a picture of the perceived extent and nature of doctors' involvement in management and then try to draw comparisons between the replies from different groups of respondents and the available literature. The data derived from this would assist in addressing my overall and associated research questions.

The Literature Search

I carried out an extensive literature search using the facilities of the University of Durham libraries including the library of the Durham University Business School. The libraries of the University of Newcastle Medical School, The University of Northumbria, The NHS Executive libraries at Quarry House, Leeds, and at John Snow House, Durham, The Information Resource Centre at The Nuffield Institute for Health at the University of Leeds, were all used and provided rich sources of secondary data for my research. At these venues I also had access to a range of official government publications including Acts of Parliament, White Papers, and Department of Health circulars. I also had regular access to a range of relevant medical and management journals.

The Fieldwork

A qualitative research approach was used for the fieldwork with semi-structured and focused types of interviewing, in an attempt to capture data on the perceptions of key informants "from the inside." This process is described by Miles and Huberman as a process of, "Deep attentiveness, of empathetic understanding (*verstehen*), and of suspending or "bracketing" preconceptions about the topics under discussion" (Miles and Huberman, 1994, p6). They consider that a main task for a researcher is to, "Explicate the ways people in particular settings come to understand, account for, take action and otherwise manage their day to day situations" (Miles and Huberman, 1994, p7). My data analysis was carried out through comparisons, interpretations, and analytical induction.

I brought a range of roles to the conduct of my research. I spent some 20 years working in managerial positions in the NHS between 1967 to 1987 and have therefore lived with the changes that had occurred over these years. I have been professionally involved with medical staff for a large part of my career, in planning, in financial and in other decision making meetings and also in the day to day operation of services. I have observed the struggle between the power of the doctors and

managerial authority and how this struggle manifests itself in a multitude of ways. I could therefore interpret and evaluate the literature in the light of my own experience of the events and happenings and I could balance the literature with my own first hand knowledge of the cultural experiences, the professional relationships and major issues that have occurred during this time.

I was aware that someone from outside the Health Service would look at things in a different, perhaps more "objective" way simply because he/she is an "outsider." Although I spent some 20 years working in managerial positions in the health service, I was now myself an "outsider", having retired early from the service. I was therefore in a position of being able to view the service from my previous professional knowledge base and from my present outsider perspective. Nevertheless I was conscious of the fact that it is an impossible task for the researcher (whether an insider or outsider) to have no impact on the researched - this is not an aim in qualitative research.

I would argue however, that I could not have conducted this study by relying only on the literature and the data derived from the fieldwork. The study required more than that, it required a knowledge and deeper

understanding of the culture, the professional relationships, and the politics of this unique organisation. My knowledge and understanding of the service allowed me to be one of my own key informants, a position which I feel has added to the richness of the study rather than detracting from it.

Research Approach

According to Long, "Research is conducted to solve problems and to expand knowledge. It is a systematic way of asking questions, a systematic method of enquiry. Research is about illumination...Research should fire the curiosity and the imagination...If people feel that research illuminates their understanding and gets into their thinking, then it is of some use." He states that, "Research is the systematic collection, analysis and interpretation of data to answer a certain question or to solve a problem" (Long, 1991, p1).

The research which I conducted was part-time over a five year period commencing in April 1994. It was based on an extensive literature search and fieldwork over a two and a half year period, followed by the data analysis which took a further year to complete. The remaining time was spent assembling the information and refining my thesis for presentation.

The objective of qualitative research is, "The development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, giving due emphasis to the meanings, experiences and views of all the participants" (Pope and Mays, 1995, p43). This definition is particularly useful in demonstrating how qualitative social science methods in health services research differ from the quantitative methods familiar to many health professionals which are deductive in reasoning and rely heavily on statistical sampling and experimental, survey methods.

In many respects qualitative methods of research have been, and perhaps still are, considered inferior to the quantitative methods employed in clinical trials and biomedical research. There has however been a growing awareness that qualitative methods in health services research, and indeed in many other areas of research, allows us to access areas not amenable to quantitative methods. "Qualitative interviewing is a flexible and powerful tool which can open up many new areas for research" (Britten, 1995, p253). The qualitative method is inductive rather than deductive (Pope and Mays, 1995, p43), it has an investigative, exploratory and discovery approach, with the main emphasis being on the discovery

and generation of theory, although existing theory can often be used as a starting point.

In qualitative research it is the development of ideas, arguments, concepts, categories and theories from the data which is important. There is thus an element of an open ended, flexible approach. The issues, questions, data collection and analysis emerge from the research process. It is the skill of the researcher that extracts what is meaningful from the data, deciding which leads need to be followed up and which should not be pursued.

An appropriate design is essential to all research studies. The following principles illustrate this point. Therefore my study was designed bearing in mind:-

i) Ethical Design

The study should meet agreed ethical standards/ criteria. For example, who may be harmed by the conduct of the study? What precautions are taken to protect the participants from harm? What value has the study for participants? Has the study observed confidentiality?

ii) Design Efficiency

The study is efficient - in terms of its informativeness, size, and cost.

(Long, 1991, p3).

In addition I was aware that all research must pay attention to the issues of reliability and validity. In

the opinion of Mays and Pope, the two goals that qualitative researchers should seek to achieve are:-

Reliability

i) To create an account of method and data which will stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions.

Validity

ii) To produce a plausible and coherent explanation of the phenomenon under scrutiny.

(Mays and Pope, 1995, p110).

In order to enhance the reliability of my research, I have maintained detailed records of my interview tapes and interview scripts together with my own observations and notes taken before, during and after each interview. The raw data analysis derived from the interview transcripts has all been recorded and coded into the various categories which emerged as the analysis progressed. The process of the analysis has been documented in some detail and retained.

To give attention to the validity of my research I deliberately chose to interview and seek views from a wide range of different informants, who, because of their professional background and position in the organisation would be likely to have differing, and in some cases, directly opposing views. In order to test the validity

of my analysis and interpretation of the interviews I had with some of my key informants, I have returned to a selection of informants and discussed with them my analysis and interpretation. The purpose of this was to see if they felt that this was a reasonable account of their experience and responses. They confirmed that this was so.

These principles of research provided me with the foundation stones of my study, I would undertake a "Systematic enquiry directed towards discovery and the development of an organised body of knowledge" (Long, 1991, p1).

In the qualitative research I conducted, the data obtained was mainly from the points of view of medical professionals and managers. I wanted to know about their professional interactions and relationships, their views on the NHS reforms, their attitudes to management, their opinions, their perceptions, expectations and their understanding of what more active involvement of doctors in management would mean. A qualitative approach to research provided me with the means to explore these areas in depth in order that I could understand better the complex nature of modern health care.

The element of flexibility was important in my study because the study involves policy and systems which are changing rapidly (Smith and Cantley, 1985). An example of this is how social policy changes impinge on many aspects of health service organisation and management; an area I shall explore later in this thesis (see chapters 2-3).

This is not to say that I am an advocate of the qualitative method of research as opposed to the quantitative method or that the two should be kept separate. Quite the opposite. Indeed, in the aspect of health services research which focuses on the clinical outcomes of therapies, many historic advances have been made using quantitative methods such as in randomised controlled trials. I rather see the two methods as complementary to each other, indeed in many respects essential to each other. For example, a quantitative study which counts and differentiates the numbers of people smoking, or drinking "excessively" in different groups of the population, may be a necessary precursor to a qualitative study which explores the question, "Why do people continue to smoke or drink excessively when it is a known and definite health risk so to do?"

The tests of reliability and validity pose different

problems in the two methods. Quantitative methods aim for reliability (consistency on retesting) through the use of tools such as standardised questionnaires, whilst qualitative methods may score higher on validity because they explore what people actually mean when they describe experiences, attitudes, views etc. (Pope and Mays, 1995, p43).

Pope and Mays take the view that, "In health services research the differences between quantitative and qualitative research methods continue to be overstated and misunderstood" (Pope and Mays, 1993, pp315-8). There is still a failure to understand that the quantitative-qualitative distinction has created an unnecessary divide which does not encourage movement between the two camps (Pope and Mays, 1995, p43), indeed it would be "more fruitful for the relation between qualitative and quantitative to be characterised as complementary rather than exclusive" (Pope and Mays, 1995, p44).

In their opinion, qualitative research, "Can be especially useful in looking at health services in times of reform or policy change from the point of view of the patients, professionals and the managers affected" (Pope and Mays, 1995, p45), whilst Pollitt, Harrison, Hunter and Marnoch, consider that "The value of qualitative research

in health services is becoming increasingly widely recognised in studies of health service organisation and policy" (Pollitt et al, 1990, pp169-90).

The main criticism of qualitative research, especially in the health field, which is more used to the quantitative and experimental methods, is that it lacks "scientific rigour" (Mays and Pope, 1995, p109). To combat this, the basic strategy to ensure rigour in qualitative research is systematic and self conscious research design, data collection, interpretation and communication (Mays and Pope, 1995, p110).

Whilst accepting that qualitative research has its weaknesses as well as its strengths, so also has the quantitative method. Indeed quantitative research, for so long considered to be the "gold standard" can be seriously flawed. According to Dingwall:-

"One of the greatest methodological fallacies of the last half century in social research is the belief that science is a particular set of techniques: it is, rather, a state of mind, or attitude, and the organisational conditions which allow that attitude to be expressed."

(Dingwall, 1992, p161).

As in qualitative research, it is true that quantitative research will similarly be dependent on the judgement and skill of the researcher and the

appropriateness of the question answered. "All research is selective, there is no way that the researcher can in any sense capture the literal truth of events" (Mays and Pope, 1995, p109). Brooks and Baumeister in criticising the "mechanics" of some research methods go further when they contend, that by rigidly adhering to the rules, "We are making a science of missing the point" (Brooks and Baumeister, 1977, pp543-546).

Deutscher considers that quantitative research may well lead the researcher "Up a blind alley." In the opinion of Deutscher, in quantitative research, "There are always other variables to consider and so we never discover that it is a dead end" (Deutscher, 1973, p40). It is therefore virtually impossible to get a holistic picture without some element of the qualitative method. It would appear that quantitative research and its advocates, place more emphasis on precise measurements than on important ones. Deutscher neatly sums up the criticism of quantitative research:-

"We have in our pursuit of reliability, been absorbed in measuring the amount of error which results from inconsistency among interviewers or inconsistency among items on our instruments. We concentrate on consistency without much concern with what it is we are being consistent about or whether we are being consistently right or wrong. As a consequence we may have been learning a great deal about how to pursue an incorrect course with a maximum of precision."
(Deutscher, 1973, p41).

Quantitative approaches attempt what many would argue is an impossible task in social research, i.e. for the researcher to have no impact on the researched and to be a "objective" observer of events, responses and other phenomena. Qualitative approaches acknowledge, incorporate and make use of the researcher as participant and social actor thus adding to the richness and depth of the data.

Interview types

Interviews were an important element in the fieldwork for this research. In the words of Ackroyd and Hughes, the fundamentals of interviews and the interpretations which researchers make as a result could be defined as:-

"Encounters between a researcher and a respondent in which the latter is asked a series of questions relevant to the subject area of the research. The respondent's answers constitute the raw data analysed at a later point in time by the researcher."

(Ackroyd and Hughes, 1983, p66).

It is not necessary for a researcher to strictly follow any one particular method of interview, indeed many researchers interchange their methods between two or more of the main types. However, in order to determine the type(s) of interview I would use in my research, I needed to examine the following four main interview methods used by researchers.

The structured interview

This method, (perhaps the most familiar) is associated with survey research and with the use of a questionnaire as the data collection instrument. The questionnaire design ensures that each person is asked the same question in the same way to eliminate "noise", i.e. to try and eliminate other variables which could become confounding factors. This method allows comparisons to be made and relies upon a uniform structure. The choice of responses is also standardised, pre-determined and limited, for example, to ticking a box (May, 1993, p92). This type of interview would not however have allowed me to explore opinions, complex professional relationships, attitudes to management and so on. It was also unsuitable for a subject area where there is uncertainty and complexity, such as the one I was about to embark upon.

The Semi-Structured Interview

This interview method utilizes techniques from both the focused and structured methods. In the opinion of May, "The questions are normally specified, but the interviewer is more free to probe beyond the answers in a manner which would often seem prejudicial to the aim of standardization and comparability...the interviewer can seek both clarification and elaboration on the answers given" (May, 1993, p93). These are two of the main

characteristics of the semi-structured type of interview, and they allow the interviewer to have more scope to probe beyond the answers which are given. This was therefore applicable to the research I wished to carry out and offered an opportunity which neither the structured interview nor the use of postal questionnaires affords. The semi-structured interview widens the parameters of discussion in the interview process and allows people to answer questions in their own words and on their own terms. The greater degree of latitude which this method allows means that, "The context of the interview is an important aspect of the process" (May, 1993, p93), and thus of the research data. For this reason it is usual for the researcher to carry out this type of interview himself, which I did, rather than rely on the services of trained interviewers (May, 1993, p93) and to make "research notes" about the interview. Interviewers can never be sure that their respondents feel confident enough to be open and frank, but my "insider-outsider" position and the relatively informal nature of the interviews, plus reassurances of confidentiality, aimed to reduce the likelihood of people saying what they thought they *should* say.

The Focused Interview

The "open ended" nature of this type of interview is

its main strength and characteristic. In the opinion of May, it can, "Directly involve the researcher as subject and co-participant in the data collection process" (May, 1993, p92). Paget considers this type of interview to be a "dynamic process whereby the researcher seeks to gain knowledge" (Paget, 1983, p88), by which she means "illuminating" human experience (Bryman, 1988, p116).

The choice of interview techniques I used encouraged a fair degree of latitude from my informants, which was quite different from the approach a quantitative researcher would have used in the survey approach. I made use of an interview schedule (see Appendix I) which I had forwarded to my informants prior to the interview. However, I allowed my informants to "ramble" to a limited extent, very often usefully illustrating the points being made. As Measor explains:-

"Inevitably the interviewee will "ramble" and move away from the designated areas in the researcher's mind. "Rambling" is nevertheless important and needs some investigation. The interviewee in rambling is moving onto areas which most interest him or her. The interviewer is losing some control over the interview, and yielding it to the client, but the pay off is that the researcher reaches the data which is central to the client."

(Measor, 1985, p67).

In the structured type of interviewing "rambling"

would be regarded as a considerable nuisance, but in the semi structured type of interviewing, such as that which I employed, a phenomenon like rambling can, in the opinion of Bryman:-

"Be viewed as providing information because it reveals something about the interviewee's concerns. Unstructured interviewing in qualitative research then departs from survey interviewing not only in terms of format, but also in terms of its concern for the perspective of those being interviewed."

(Bryman, 1988, p47).

Bryman, referring to the focused interview, states that, "A phenomenon like rambling can be viewed as providing information because it reveals something about the interviewee's concerns" (Bryman, 1988, p47).

The focused interviewing method achieves a particular set of objectives:-

(i) It provides qualitative depth by allowing interviewees to talk about the subject in terms of their own "frames of reference."

(ii) This allows the meanings and interpretations that individuals attribute to events and relationships to be understood.

(iii) It provides a greater understanding of the subject's point of view.

(May, 1993, p94).

May considers that, "The focused interview obviously involves the researcher having an aim in mind when conducting the interview, but the person being interviewed

is more free to talk about the topic. Thus flexibility and the discovery of meaning, rather than the standardization, generalization or a concern to compare through constraining replies by a set interview schedule, characterize this method" (May, 1993, p94). The focused method of interview allows the researcher to be directly involved, as I was to a degree, as a subject and co-participant in the data collection process (May, 1993, p92). The objective is to obtain rich and detailed descriptions from the person being interviewed, i.e. concerns, opinions, actions and so on in the respondent's own words.

An essential emphasis in this type of interview is not on control, but on an understanding of the meanings intended. The respondent is given freedom to choose his/her own main area of importance within the broad outline of the research area and to place the emphasis where he/she feels it should be. The respondent is encouraged to see him/her self worthy of study and to feel that the views and opinions he/she holds are respected and important. Precision in meaning is essential, interest lies in getting as close as possible to the respondent's understanding and interpretation of the matter under discussion. The researcher, who is attempting not to influence the respondent in a way which would bias the

response, should be as responsive and receptive as possible to whatever the respondent may say. In this way, an interview highly charged with information and meaning can result.

Group interviews

The above discussion has focused on interviews with individuals. A researcher also, however has the option of interviews with groups of people. Group norms and group dynamics are features of this type of interview which constitutes a valuable tool of investigation. I did not feel however, that group interviews would be appropriate to my research, not only because of practical problems i.e trying to arrange one time that a number of people could meet, but I doubted whether my respondents would be as forthcoming with their individual experiences, in a group setting.

Research methods using interviewing techniques pose considerable analytical problems. For example are people telling the "truth", what knowledge do they have of the subject area, does the very fact of interviewing distort the data? (Strong and Robinson, 1990, p7). Nevertheless, by careful selection of those persons to interview and by using the semi structured and focused methods of interviewing and the use of extensive quotations from

those interviewed, I attempted to capture the richness of the data from their replies and thus generate good and meaningful data. Only in this way, did I feel that I could do justice to the replies from these key informants, many of whom hold positions perceived as highly skilled and high status in the very complex task of managing the vast organisation that is the NHS.

The selection of interviewees: Key Informants

The "key informants" approach I used in my study was similar to the approach used in a qualitative study carried out by Pollitt, Harrison, Hunter and Marnoch in 1990, into the effects of the introduction of general management into the Health Service (Pollitt et al, 1990). They sought the accounts of doctors, managers, and patients' advocates in order to assess whether power relations had shifted appreciably in favour of professional managers as against the medical profession. The attraction of this approach is that it rules out respondents who have no knowledge of the subject area yet still allows access to a wide and diverse sample group. The strength of this approach lies in the depth of information these respondents can produce on complex issues.

My aim was to select for interview only those people

who had either a professional knowledge of the subject of doctors in management or who were involved in some way in the subject area at a senior level and people who were aware of the background of the subject area, the politics and the evolving concept of doctors in management. I wanted to have a mix of clinical and non clinical informants; academics who had studied this particular area; other health professionals, also those professionals who could stand back from the operational issues and view matters in a broader context.

I thus drew from a variety of occupational groups. I wanted to be able to draw comparisons between those who viewed more active involvement in management by medical staff to be desirable and those who did not. I also wanted to be able to contrast the views of those in formal managerial positions of authority (i.e. Chief Executives) and others in senior management positions, with the views of those in positions of power derived from their professional status i.e. Consultant medical staff, Medical Directors/Clinical Directors and others.

Having decided on the requirements for inclusion in my sample, I then needed to find my "key informants." Realistically this approach, with a few exceptions, had to be confined to those employed in the North East of

England. My main focus was on secondary care and on Acute Hospital Trusts since it is here that the tensions between the power of the doctors and the "rational-legal authority" of lay managers seemed most evident. Initially I approached the Chief Executives of some of the NHS Trusts in my geographical research area. In addition to asking them to be "key informants" themselves, I also asked them for copies of their management structures and the names of the occupants of the key positions (clinical and non clinical) in these structures. As a courtesy to the Chief Executives I also asked if I might approach certain members of these staff by letter with a view to asking them for an interview. With regard to those respondents who were not employed in the Trusts, I made a series of telephone calls to secretaries, receptionists and so on, in order to establish the names of the people holding the positions I was interested in, in these other organisations.

Using these criteria, and in order to achieve a group of respondents with a range of characteristics, my "key informants" were selected on an "opportunity sample basis", i.e. a deliberate choice of respondents as opposed to statistical sampling (Pope and Mays, 1995, p42), trying to cover a variety of professions and a good spread of different NHS organisations in the area. Freeman refers to

this tendency in organisation studies to obtain samples opportunistically rather than according to random sampling procedures (Freeman, 1986, pp298-303). The nature of my small-scale, opportunity sample means that the experiences and views reported cannot be generalised to doctors, managers and academics elsewhere. However, the approach (with the promise of complete anonymity) produced a high response rate and a willingness and ability to talk in depth and at length about the central issues with which the thesis is concerned. The limitations of the research are acknowledged, for example I would have liked to enlarge the sample size and extend the geographical boundaries of my fieldwork research had resources permitted. However, it is worth mentioning that although my respondents were currently based in the North East, almost all had worked in the health service in other parts of the country and therefore their replies were influenced by this wider experience.

Access

The problem of access was one of which I was acutely aware. I had been warned by academic researchers that it was almost impossible to get interviews with consultant medical staff. I was also aware that these consultants considered themselves to be very busy people who don't take lightly to research students exploring their domain.

Nevertheless their participation was central to my research so I set about trying to gain access to them.

In the event, possibly by virtue of my previous health service employment, with the exception of one consultant, all agreed to see me, medical professionals and others. Indeed I got the distinct impression on some occasions during the interviews that they were rather pleased that someone with a health service management background had at last recognised that the views and opinions they held were deserving of respect and were important! When I approached one General Medical Practitioner and asked for a half hour interview, he almost exploded, saying that he only allows his patients 5 minutes. He then agreed to see me and talked for well over an hour!

With the prospective problems of access in mind, I spent some time deciding how best to approach my key informants. Should I see them "cold" with only the briefest of information relating to my research area given before the interview, or should I forward an outline, prior to the interview, of the specific areas of discussion I had in mind?. I was conscious of the advantages and disadvantages of both approaches. The advantages of the former method were that I would get

spontaneous replies to my interview questions without so much danger of the interviewees working out what they thought they should say. However, I doubted whether I would get the in depth replies I wanted, since I knew that many of my questions required some thought beforehand. I also doubted whether this approach would gain me access to these key informants since many of them are cautious of interviewers, some have already had bad experiences with press interviewers and are very reluctant to be interviewed "off the cuff."

I decided on the latter approach, primarily because I thought it would ease access problems, but also that it could add to the quality of the replies and produce more in depth data. In addition, also in the hope of easing access, I included in a letter, brief information about myself, to the effect that I had completed my career in NHS management and had then successfully completed a Masters Degree in Health Services Studies at the Nuffield Institute for Health at the University of Leeds. The letter also included the name, designation and telephone number of my supervisor, who could verify the content of my letter. The letter is in Appendix II.

This approach, together with the decision to forward an interview schedule prior to the interview, outlining

the main areas of discussion, proved to be successful in gaining access to my key informants.

In total I interviewed 30 people individually, five of whom formed part of my pilot scheme to test out the research questions on the interview schedule, before embarking on the main body of the fieldwork. This pilot enabled me to amend and refine the interview schedule several times before proceeding since this would form an important part of my research approach. However there was sufficient similarity between the pilot interviews and those in the main study for the former to be included in the main analysis. The key informants in my study all had considerable experience of health services management and held or (in one case) had held, senior positions in the National Health Service or in academic institutions. A list of the occupational categories of the people interviewed is in Appendix III.

Conducting the interviews

For my fieldwork, which took place during the summer and autumn of 1996, I visited NHS organisations in the North East of England, some on several occasions, together with a visit to the Health Economics Consortium at the University of York and to the British Association of Medical Managers at their headquarters in Barnes Hospital,

Cheadle, Cheshire. (See Appendix IV). At each of these visits the interviews were conducted with only the informant and myself present. The interviews lasted on average one hour and, with the exception of two interviews, all were conducted using a tape recorder. The two informants who declined the use of a tape recorder felt that they could speak more freely without a tape recorder being used. Both informants agreed that I could take notes as they were speaking, which I did.

It was a mix of the semi structured and focused types of interview which formed the basis of my data collection method, with strict confidentiality and anonymity of all key informants being observed throughout. All my data transcripts were anonymised and given code numbers, the key to which I restricted to myself. I also made notes, before, during and after each interview to supplement the taped material.

Analysis

Strong and Robinson, in their study of "The NHS, Under New Management" following the implementation of the 1983 Griffiths Report, used extensive quotations in the analysis of their study, primarily because, as their informants "were experts and the NHS so vast and varied", (Strong and Robinson, 1990. p9) they felt that "only

detailed quotation could hope to give a real flavour of Griffiths and the organisation it sought to transform" (Strong and Robinson, 1990, p9). I felt the same way with the analysis of my fieldwork. This is why on some occasions the evidence for my argument is drawn, as in the Strong and Robinson study, from a number of quotations grouped together to illustrate the point being made. Some of these quotations are short, others long and complex, the purpose however is always to try and retain the richness of the data which in some instances fragmentation may have destroyed.

All the interview tapes, together with notes taken before, during and after the interviews were transcribed and formed the basis for the coding of themes and concepts identified from the data, which have been included in the text of my thesis. Notes from the two interviews where my informants declined the use of a tape recorder were similarly typed and put into the same format as my other data for coding, analysis, and subsequent inclusion.

I was aware of the various computer software packages available to facilitate the analysis of the content of interview scripts, but in my case, mainly because of an ageing (but faithful) computer which was not compatible with data analysis software, I adopted the "long couch"

method of coding the interview transcripts manually and dissecting the data into the answers to each interview question. My data analysis was carried out using analytical induction techniques, comparisons, and interpretations.

Analytical induction

Analytical induction with its stipulated requirement that research comes before theory and that theoretical propositions derive from the data, is based on the belief that, as with empiricism, we can proceed from a collection of facts and then make links between these facts to arrive at our theories (May, 1993, p22). By using constant comparisons between the various categories into which I had grouped my fieldwork data, I was able to develop hypotheses which I could then test as my data collection and analysis proceeded.

Comparisons and Interpretation

I grouped the answers to my interview questions, or in some cases part answers, into various categories in numerous ways in order to extract from, but still remain true to the original data. For example I categorized the responses themselves into topics of interest, then by respondents' occupation, by clinician as against non clinician, by those for and those against the more active

involvement of doctors in management, the views of academic staff as against those actually working at operational level and so on. In this way I was able to draw comparisons and be able to interpret various views and strength of argument amongst my key informants, to explore possible links between occupation and views and links between views on a variety of issues. From the interview schedule and the data gathered I was able to develop research themes, and then arrange the data into these themes. This thematic approach has been used to present the data in chapters 7-9.

In this chapter I have outlined my research, the methods used and the means of analysis. In the next two chapters I shall examine some of the government initiatives and major reorganisations and reforms in health and in social policy which have taken place from about the early 1970s. Many of these changes were attempts to break into the closed world of clinical performance and clinical effectiveness, thereby trying to reduce the power of medical consultants in favour of managerial authority.

CHAPTER TWO

THE CHANGING SCENE

Major reorganisations and reforms have been a feature of the National Health Service throughout its 50 year history. At the time it was thought that the reorganisation of 1974, which restricted local authority involvement in the provision of health care to environmental services and which introduced "consensus management" into the NHS (Edwards, 1993), was radical and far reaching, however the 1980s and early 1990s saw even more monumental shifts in the way the health service operated. As well as being in some instances, radical organisational changes, they also involved important policy and philosophical shifts which had important implications for doctors in management.

The objective in this, and in the next chapter, is to show how, throughout the reforms and reorganisations which took place up to the early 1990s, the role of doctors in the management of secondary care was powerful and

influential, but, with the exception of a small number of doctors who had taken on management positions, the role was largely informal, with little or no individual responsibility or accountability for non clinical matters, indeed only a very limited accountability even in clinical matters.

It is true that doctors have always had a very strong formal presence on high powered national committees such as the General Medical Council, the British Medical Association, the Hospital Consultants' and Specialists' Association, the committees of the Royal Colleges and on local committees as well as their membership of the various local bodies running secondary care and contracting with GPs, but this presence did not normally incur individual accountability or responsibility outside the clinical field. They could always hide behind collective committee decisions. Indeed so great was the influence of doctors by virtue of their membership on these committees that the large majority felt it quite unnecessary to be formally involved in management and all that that entailed, since they could normally achieve their clinical and non clinical objectives simply by relying on their power and influence.

To illustrate the thinking in the medical profession

we can look at a statement by Dr Ross, a British Medical Association spokesman who, in 1985 gave his interpretation of the objectives of the National Health Service:-

"The concept of The National Health Service was to provide an administrative system within which doctors treated patients in the light of their professional judgement. The National Health Service is just the system that pays the bills and provides the hospitals and all that."

(Ross, 1985).

This statement by Ross, although devastating in its simplicity, was none the less, essentially true. The National Health Service was administered and organised on that basis from the very beginning with administrators very much subservient to doctors.

There was thus a divide between the power of the doctors and the authority of the manager from the birth of the health service. I shall argue in this thesis that herein lay one of the fundamental flaws in the administrative and management systems of the National Health Service which reorganisations and reforms have failed to properly address. In a service as large and complex as the National Health Service it would be unwise to regard this divide as the single factor responsible for the discord and uneven development of ideas in the service. A number of contributory factors can be identified (Ham, 1985, pp204-206). However, the

separation of power and authority certainly played a major part.

The reforms of 1974, the Health Services Act 1980, the Griffiths Report of 1983 and the passing of the National Health Service and Community Care Act of 1990, all had one central theme: that the health service must find a way to get better value for money in the services it provides for patients.

The 1948 Structure of the NHS

Before examining the major reforms which have taken place from about the early 1970s it is necessary to give a very brief outline of the debate, which in the main involved medical staff and politicians, which took place before and just after the launch of the National Health Service.

When the NHS commenced operation on 5th July 1948 there had already been nearly 50 years of debate and argument about the formation of a unified network of health services in the U.K. The then Minister of Health, Aneurin Bevan, produced a White Paper in 1946 which committed the government to a "free and comprehensive health service and went on to propose the nationalisation of all hospitals to create a truly national service"

(Edwards, 1994, p35). The plan met with considerable opposition from the British Medical Association who were worried about the effects of state control on medicine and of an enforced salaried service for general practitioners. Because of this strong pressure from the BMA, compromises had to be reached to allow the plan to go forward. Some of the compromises relate to the agreement which ensured that the medical profession would have a voice on all statutory committees in this new health service, and that doctors' clinical freedom and clinical autonomy would be preserved. General practitioners were allowed to retain independent status and contracted their services to the new Executive Councils (Edwards, 1994, p36).

The original structure of the NHS was formed in three parts, a tripartite structure made up of Local Health Authorities, who would be responsible for community health care, domiciliary services, vaccination, immunisation, and ambulances, whilst the Regional Hospital Boards, of which there were 14 at first (subsequently 15) (Levitt and Wall, 1992, p11) would be responsible for hospital services through Hospital Management Committees numbering some 400 in total (Ham, 1992a, P16), with Boards of Governors responsible for 36 teaching hospitals. The third branch of the structure consisted of the Executive Councils (138) to whom self-employed general practitioners, dentists,

opticians and pharmacists would relate (Edwards, 1994, p36).

It is interesting to see that in the first year of operation of the NHS it produced an overspend of 36% against target. The second year of operation the estimated budget of £228 million turned out to be £305 million (Edwards, 1994, p36).

National Health Service - Overall objectives

The overall objectives of the NHS are contained in the National Health Service Act 1946:-

"...to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis and treatment of illness."

(Ministry of Health and Department of Health, Scotland (1944) Cmd 6502).

In this new NHS, everyone was entitled to the service with access to resources on the basis of "need" as defined by doctors, so in practice the main focus was on "diagnosis" and "treatment", not the health promotion and prevention objectives mentioned first in the Act. Doctors would have no interference in their clinical judgement and benefits would be available to everyone free of charge on the basis of need (Levitt and Wall, 1992, p11). Health service funding was from compulsory national insurance for

workers and general taxation (Edwards, 1993, p4).

The centrality of medicine and doctors in the NHS has since been reinforced on a number of occasions by official pronouncements. In the view of Stacey, doctors insisted on retaining clinical autonomy, and enshrined in the "grey book" which was the bible of the 1974 reorganisation (discussed later in this chapter) one sentence removed them from the managerial authority to which all other health-care professionals and workers were now to be subject (Stacey, 1988, p127).

"The management arrangements required for the NHS are different from those commonly used in large organisations because the work is different. The distinguishing character of the NHS is that, to do their work properly, consultants and general practitioners must have clinical autonomy, so that they can be fully responsible for the treatment they prescribe for their patients. It follows that these doctors and dentists work as each others' equals and that they are their own managers. In ethics and in law they are accountable to their patients for the care they prescribe, and they cannot be held accountable to NHS authorities for the quality of their clinical judgements so long as they act within broad limits of acceptable medical practice and within policy for the use of resources."

(Department of Health and Social Security, 1972b).

It would seem that from the outset the NHS has had two major problems, one relating to money, the other relating to power. The power of the medical profession

was evident at its inception and has remained so. Not only was it successful in negotiating compromises with the Minister of Health, but was also allowed to bypass the Whitley Council machinery which had been set up to negotiate wages and terms and conditions of service for all NHS staff, the medical profession being allowed to negotiate directly with the Minister of Health (Edwards, 1994, p36).

The 1974 Reorganisation

An important date for the management process in the National Health Service was 1st April 1974. In order to integrate its various component parts into a more unified structure, a major reorganisation took place, with the tripartite structure being replaced by newly created Area Health Authorities who assumed line responsibility for all hospital services (Marnoch, 1996, p17). Some 700 different authorities were swept away in this reorganisation which created 14 Regional Health Authorities to manage 90 Area Health Authorities who in turn managed 206 District Management Teams. The Area Health Authorities managed the community services, the hospitals and the ambulance service, and also held the contracts of general practitioners, opticians, dentists and chemists through Family Practitioner Committees. (Edwards, 1994, p38).

The reduction in the Local Authority role could be seen as strengthening the medical model by bringing formerly Local Authority based community services into structures dominated by acute medicine. Teams of managers including doctors and nurses were introduced at each of the three levels, Region, Area and District. The management style at each level would be "consensus management", whereby all members of the team had to agree decisions, (or agree to differ) with a power of veto accorded to each team member. All team members, in managerial terms, were equal. The power of the doctors was not the only force behind the introduction of consensus management at that time. The other key clinical group, nursing, played a fundamental role (Strong and Robinson, 1990, p19).

A massive extension of nursing power manifested itself in 1974 with the new Chief Nursing Officers in each of the Health Districts in charge of vast nursing budgets. The new Regional Health Authorities and Area Health Authorities now had nursing, as well as medical representatives on their management teams. A new dawn for nursing, in managerial terms, had emerged, they were part of the consensus management arrangements and were now sitting at the top table (Strong and Robinson, 1990, p19).

Brown's principal conclusions following his study of Humberside health services were that structural change of the kind carried out in 1974 had serious drawbacks (Brown, 1979, pp199-200). He concluded from his study that reorganisation involved heavy costs in terms of disturbance and delay in ongoing management processes. Managers were expected to manage the reorganisation and the service at the same time. However, most of the costs arose from the structural changes themselves which increased permanent running costs and generated over optimism about the net advantages to be gained (Brown, 1979, pp199-200).

Challenges to the Welfare State

Even before the Conservative government came into office in 1979, to begin, as it turned out to be, a span in office of 18 years, the Labour Government, under Prime Minister Callaghan, had already been making cutbacks in Welfare State services, including the Health Service. The tight constraints on health service finance were partly due to the economic crisis of the mid 1970s when the price of oil escalated causing severe contractions in the world economy (Harrison et al, 1990, p37), although demand had outstripped resources since the inception of the NHS.

The democratic consensus between the two main parties, the Labour Party and the Conservative Party, was under strain in the wake of this economic crisis with welfare spending perceived as out of control. The old confidence in the Welfare State began to fade.

It was against this background that in 1979 the Conservative Party, under the premiership of Mrs Thatcher, came to power. The Conservative Party was committed to significant reductions in public sector spending linked to monetarist policies in order to restore the role of the market in a wide range of services. The macro economic policy of the Conservative government was based on the view that the Public Sector Borrowing Requirement should comprise a declining proportion of Gross Domestic Product. A manifestation of this trend has been the falling rates of growth in real spending on health care over much of the subsequent period (Harrison et al, 1990, p38).

The Conservative Government were committed to an ideology which considered market forces should be the dominant factor in the allocation of resources. They believed that economic difficulties were due to high welfare state spending. Conservative policy moved even further to the right towards an ever-increasing reliance on the private sector, ideological imperatives adding to

the pressures arising from perceived economic crisis. The new way of thinking was to be independence of, rather than dependence on, the State (Klein, 1995, p134).

Allsop considers there were a number of themes running through the rhetoric and policies of the Thatcher administration. The first and predominant theme, in Allsop's view, was the aim to reduce public expenditure, a second theme was a belief in the benefits which would accrue if principles of private sector management were applied to government, a third theme was the encouragement of self help and a transfer of the burden of provision from the state towards the community and the family. An example of all these principles/themes was the encouragement of private health insurance. The fourth theme was the encouragement of competition within the public sector, including private companies being allowed to compete for areas of work within the health service (Allsop, 1995, p156).

Each of these themes has a particular relevance for NHS medical staff. Any reduction of spending in the health service inevitably impacts on clinical services directly or indirectly regardless of the rhetoric that "patient services will not be affected by these reductions." Allsop's second theme, the empowerment of

managers through the introduction of private sector management principles into the public sector could be seen by medical staff as an attack on their clinical autonomy, whilst the third theme could mean a reduction in secondary care provision relative to that provided in the community and a consequent shift in the balance of power and responsibility from the secondary care medical consultant to the primary care general medical practitioner as well as from professionals to "the community." Allsop's fourth theme, the encouragement of competition within the public sector, and between the public and private sector, not only has a direct bearing on the provision of support services in the health sector including clinical support services, but also has the potential to set hospital against hospital, doctor against doctor.

One element of the way forward chosen by Mrs Thatcher and her government, was to use control of money supply and cash limits as a way of disciplining labour and thereby severely undermining trade union power. Strikes and industrial action which the general public had seen in abundance during the latter days of the Labour Government, and which in the NHS, Klein argued, had had an adverse effect on clinical services and on the ability of doctors to treat their patients, would now mean people losing their jobs in the NHS, rather than being weapons to be

used to promote better working conditions and higher wages (Klein, 1995, p102).

Greater control for the individual citizen was advocated, with less dominance by the State, more consumer freedom and more private enterprise. A complete change in philosophy was considered necessary to promote growth in the economy, which in turn would provide whatever public finance was still considered necessary for health and other public services.

The Health Services Act 1980

The Health Services Act 1980 made further major changes in the organisation and management of the NHS. The Area Health Authorities were abolished, new District Health Authorities (192 of them) were created, Districts became the main operational authorities, the "Unit" was established as the local management tier and professional consultation and planning procedures were pruned (Health Service Act, 1980). These changes were primarily a response to the perceived inefficiencies and rising costs of the NHS. Staff numbers had increased by 30% in the past decade (except ancillary staff) and government spending on the NHS was up by over 28% in real terms (Edwards, 1994, p41).

Resource Allocation

The government continued to look for ways, not only of getting better value for money, but also to try and overcome variations in cash allocations between the Regional Health Authorities. The inequality of investment between English Regions had been a bone of contention for years. In September 1976 a formula was devised by a working party to attempt to even out the resource allocations of various Regions by using population estimates weighted by different mortality and morbidity rates to calculate needs. When the formula was first applied it demonstrated a funding gap in 1977-78 of 25 per cent between Regions. North Western Region was 10.8 per cent below a target of 100, North West Thames was 14.9 per cent ahead of target. There was a strong north:south imbalance as expected. Within individual Regions there were wide disparities between Health Authorities which all Regions set about trying to correct (Edwards, 1993, p41).

Other factors such as age structure of the population within each region were also included in the formula. The formula, which became known as R.A.W.P. (after the Resource Allocation Working Party which devised it) was adopted by the Labour government and subsequently by the

Conservative governments and applied throughout the Health Service.

Winners and losers emerged following the application of the RAWP formula even though this was not the intention. The intention was to move away from the traditional, historical way of setting budgets to a more equitable method of cash allocation through bringing those below target up to the same level as those currently above. The RAWP formula however was devised at a time when there was an expectation of an increase in funding, but at the time of application there was a period of financial constraint which meant that the objectives of the formula could only be realised through gains being at the expense of losses for others. "The overall result was that there was often no direct correlation between the amount of money a district was allocated and the number of patients it treated" (Klein, 1989, p234). After the financial year 1990/91 the RAWP formula was abandoned and a new system, based on capitation, weighted to reflect the health and age distribution of the population and the relative cost of providing services, was introduced with a start date for most District Health Authorities in the financial year 1994/95 (Longley, 1993, p18).

Private Health Care

There were strong arguments for the privatisation of health services and thus the encouragement of people to buy their own. The argument was that choice meant that the private market in health care was likely to be more responsive and efficient than a public sector monopoly. If people were not satisfied with the services received from a private health care provider, they could go to another. This choice was not available in the same way in a state dominated health service. The private market in health care was thus encouraged to grow.

In 1979 the new consultants' contract allowed full time medical consultants to earn up to 10% of their NHS earnings from private practice (Edwards, 1993, p28). Other "part time" consultants had no restriction on the amount of private work they could perform. This had a major impact, with a considerable increase in private practice, but very varied by geographical area and by specialty. This growth continued with 5.7 million people by 1988 covered by private health insurance, almost 10% of the population, and double the number covered by private health insurance when Mrs Thatcher's government came into power in 1979 (Central Statistical Office, 1987, p135). (It should be noted that not all private practice is for

people with private insurance - abortion is probably the best example of this).

The Conservative governments' aim was to further increase the number of citizens covered by private health insurance to 25% by 1990, and whilst this target was not achieved, private medical insurance sales have quadrupled over the 25 years to 1997. There are now 3.2 million subscribers providing cover for 6.5 million people (Bradshaw and Vincent, 1997, p85).

In 1989, the government's White Paper "Working for Patients", stated that income tax relief on private medical insurance premiums for people over the age of 60 years would be introduced from April 1990, a further incentive to encourage people to use the private sector for their health needs (Department of Health, 1989). Whilst the tax relief was accurately forecast to be unlikely to encourage significant numbers of elderly people to take out private health insurance, or health insurers to want to cover them, it did set a precedent and allowed speculation about its extension to other age, social or work groups (Appleby, 1992. p22). In the event, the new Labour government elected in 1997 abolished this tax relief for the over 60s in its budget on 3rd July 1997 (Bradshaw and Vincent, 1997, p85). Opponents of

this decision by the new government argued that it could encourage people over the age of 60 years to cancel their private medical insurance and rely instead on the National Health Service, adding to the waiting list problems and treatment costs of the NHS.

Private health insurance firms said that "100,000 people have cancelled policies since the budget and up to half a million were set to join the exodus" (Craig, 1997, p9), although the British Medical Association and the Department of Health insisted, "That if the number of private patients slumped, a corresponding number of doctors would return to the State sector" (Craig, 1997, p9).

Information Systems

Investigations into doctors' working practices are always a sensitive issue, potentially seen as Marnoch states as "Encroaching on the profession's hallowed ground" (Marnoch, 1996, p73). Many of the information systems installed by the Tory governments were designed to do precisely that, but perhaps in a covert way. In 1980 the government, conscious of the fact that the health service needed proper information systems which at that time were seriously lacking, set up a steering group on health information under the chairmanship of Edith Korner.

In November 1982 the first report from Edith Korner's steering group was published (Korner Report, 1982). This first report looked at certain selected areas of information currently in operation in the health service. Korner concluded, "Though much lip service is paid to the crucial and central importance of high quality statistics, few Health Authorities, Management Teams or Heads of Department currently analyse data expertly or present them intelligently in the performance of their tasks" (Korner, 1982a, Para 1.3).

This was the first of a series of six Korner reports published between 1982-1984, which led to the government adopting a range of Korner Information Systems which were applied throughout the health service and which would be used by government and others to plan and shape future changes in social policy, in management, and in the general provision and delivery of health services. These information systems, linked to computerised Performance Indicators (PIs), which were introduced in 1986 (Department of Health and Social Security, 1986), had a particular significance for doctors since they provided a means whereby, somewhat crudely perhaps, the performance, and in some respects the clinical performance, of various Health Authorities could be looked at in relation to other Health Authorities and comparisons drawn. Many

limitations exist in the interpretation of these PIs, for example no indication of quality is highlighted and league tables of performance are produced which can be very misleading. Klein states that, "They (PIs) contain much data about activity (the outputs of the NHS as measured by the number of patients treated and the number of operations carried out) but none about outcomes (the impact of the activities on the health of those concerned)" (Klein, 1995, p145).

In the opinion of Marnoch, "Strategically the league tables are potentially useful in sharpening up the environment surrounding medical management" (Marnoch, 1996, p70). However the bulk of performance management systems, as Marnoch points out, are non-medical and management driven which negates their influence as tools for influencing the performance of doctors (Marnoch, 1996, p86). "The extent to which the medical profession endorses bench-marking and clinical protocols is likely to be important in the medium term. In the longer term consumerism may prove to be significant" (Marnoch, 1996, p86).

The gap identified by Klein above was to prove highly significant in 1998 with the tragic events at Bristol Royal Infirmary where two heart surgeons continued to

operate on babies despite warnings from colleagues that their death rates were too high. Over a period of seven years from 1991-1998 and 53 operations, 29 babies died and four others were left with brain damage prompting the government to introduce league tables for death rates from October 1998 (Health Management, 1998, p6). (See later discussion on this tragedy as it applies to the differing roles of a Chief Executive who is a clinician as against a lay Chief Executive in chapter 9, p341).

Competitive Tendering

Another extensive change came to the fore in February 1983 with the introduction of competitive tendering for cleaning, catering, and laundry services. This government policy was not only applicable to certain parts of the health services, but also to other government departments, local authorities etc and was in keeping with the government philosophy that creating competition would produce better value for money.

So far as health services were concerned, the introduction of competitive tendering in certain areas had a considerable impact on the management and organisation of the service and in particular on those services supporting clinical activity provided by doctors and others. For the first time managers were faced with

drawing up detailed specifications and tenders for services in which many thousands of employees were engaged, and inviting tenders from in-house and private contractors.

Throughout the whole period of the late 1970s and into the early 1980s, trade union activity in hospitals had substantially increased, primarily because staff were becoming more and more fearful for their jobs. Klein states that, "If the 1960s gave birth to a new spirit of militancy amongst those working in the NHS...by the mid 1970s the infant had grown into a large, aggressive adult" (Klein, 1995, p100).

The government rhetoric was that competitive tendering was to obtain better value for money services. However, the reality was that it turned out to be a strong political weapon to seriously weaken the power of the trade unions (Klein, 1995, p161) in those areas of the service which doctors depended upon if they were to carry out their clinical tasks and provide medical treatment for their patients.

Most of the contracts in the early days of the competitive tendering programme (1983 - 1988) were in fact won by the in-house tenderer. The exercise had, however,

forced hospitals to look in detail at the costs of the services affected by the programme (Klein, 1995, p161) in order to successfully face the competition from the private sector. This meant, in many cases, restructuring services, putting a freeze on ancillary posts as they became vacant, and other measures designed to slim down these services. Trade Unions were forced to go along with many of these changes, or else risk members losing their jobs.

Doctors, as well as being involved themselves in militancy for the first time since joining the NHS (Klein, 1995, p102) because their earnings were falling behind on the comparability criterion put forward by the 1959 Royal Commission (Klein, 1995, p102) closely observed the protracted discussions and negotiations which managers had to be involved in with trade unions. This was unlikely to encourage doctors to get formally involved in management at this time. Consultant medical staff certainly were unlikely to see long and potentially hostile discussions with trade unions to be an attractive proposition for them. Indeed, as this research will show (see chapter 8, p301) there is evidence to support the view that the demise of trade union power (Klein, 1995, p150) following the introduction of legislation to curb the power of trade unions, was a spur to doctors to

become more interested in the organisation and management of the service in an active and more formal way.

However, once the government had "dealt" with the trade unions representing the non-professional groups, mainly by the introduction of anti-trade union legislation, and a widening of the competitive tendering programme, they turned their attention to the trade unions representing the NHS professions, in particular the doctors, and tried to bring them under control.

Finance

Throughout the period since 1979 there have been considerable increases in pressures regarding the funding of the National Health Service which have had social policy and managerial implications. Opposition leaders, senior medical staff, health service professional organisations and others, argued that the Health Service was increasingly grossly under funded, which led to a reduction both in the range and quality of services it was able to provide. Indeed the Labour party charged that "The NHS was about to collapse because of inadequate funding" (Klein, 1995, p141).

The problems of financing the Health Service however had always been a matter of major concern for the

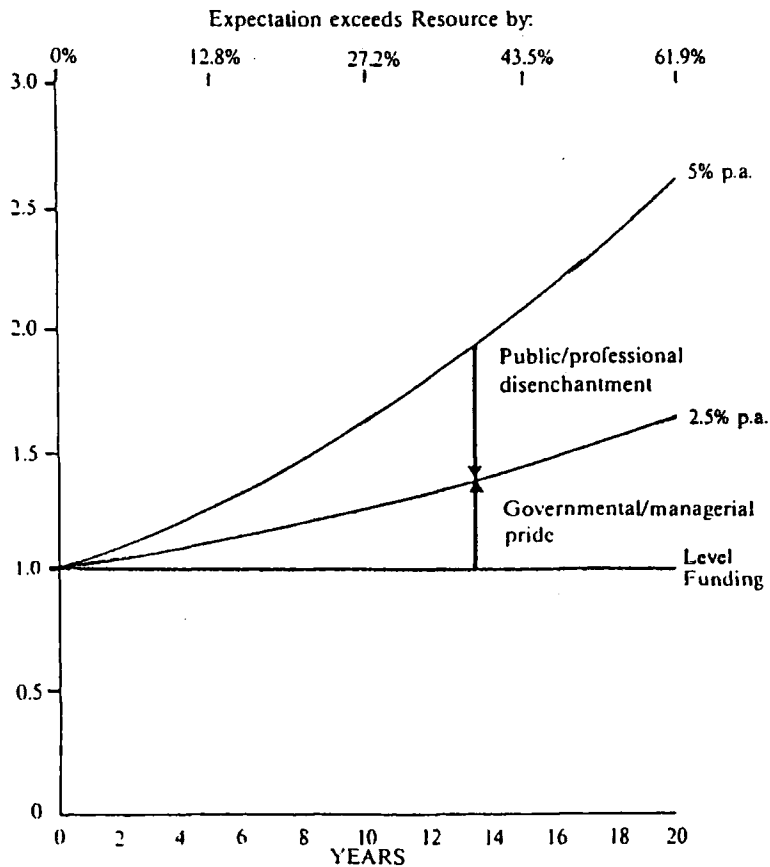
Exchequer. One factor alone, the demographic trends, was escalating the cost of running the NHS. There were many other factors contributing to this escalation in cost, not least the problem of rising public expectations. Even though additional funds had been made available to the NHS, they did not match, indeed could never match, these rising public expectations of the health service. The following extract from a lecture given by Sir Bryan Thwaites at the University of Southampton in May 1987 illustrates this point:

"Now for the reason for my laying such heavy emphasis on the exponential character of both expectation and resource is that few people seem prepared to acknowledge its implications for the long term. The point needs ramming home. In (Figure 2) (see page 70) we start with expectations and resource in balance. Let us assume that expectation then rises at the 5% p.a. that I estimated just now and that resource rises at 2.5% p.a. which is the sum of the DHSSs 0.5% and efficiency savings of 2%. These values are plausible. Within a decade, expectation will exceed resource by 27.2% and by 61.9% after another decade."

(Thwaites, 1987, pp16-17).

Thwaites concludes that the simple figure (Figure 2) explains it all. "It explains, on the one hand, governmental exasperation that the ever-increasing funding of the NHS goes unappreciated; and on the other the readiness of the medical profession and the public to believe that the NHS is being severely cut."

(Thwaites, 1987, p17).



The increasing Percentage Difference between Expectation and Resource when they grow at different exponential rates

Figure 2 (Source: University of Southampton (1987) "The NHS: The end of the rainbow")

Footnote

It is noteworthy that the two to one ratio of expectation to resource is exactly reproduced in paragraph 12 of the Fourth Report of the Social Services Committee "Public Expenditure on the Social Services." Cm.387-1 For the years 1980-81 to 1985-86, the DHSS "target" was 2% p.a. whereas resources grew by 1% p.a. (Thwaites, 1987, p17).

The National Health Service, was ever looking at ways of containing costs and making changes designed to obtain better value for money in order to finance the service. Charges for certain elements of the health service were introduced in its early years and have been increased repeatedly over the years to help meet the cost of providing these services. Among these are charges for prescriptions, eye tests, dental charges etc.

As part of this attempt to contain costs, income generation schemes were introduced in the 1980s whereby each Health Authority was required to promote a whole range of schemes to generate income which would be used to partly fund the budget for the following year. However, funding is still, and perhaps always will be, a major problem. Medical technology has advanced to such an extent that hitherto untreatable conditions are now in many instances routine procedures requiring a great deal of resources in terms of staff time and cash, people are living much longer and are being treated at a much later age, for example the average cost per head to the health service of persons in the 85+ age group is over 7 times that of people in the 45-64 age group (Cm 1913, 1992), whilst at the other end of the scale, pre-term babies are being kept alive in intensive care baby units when only a

few years ago they would have had no chance of survival. The NHS seemed to be a victim of its own "success."

The Griffiths Recommendations

In February 1983 a NHS Management Inquiry was set up by the Secretary of State for Social Services to review current initiatives to improve the efficiency of the health service in England and to advise on the management action needed to ensure the best value for money and the best possible service to patients. The leader of the management Inquiry Team, Roy Griffiths, reported back to the Secretary of State in October 1983 with a series of recommendations which were implemented by the Secretary of State and which had profound repercussions for the management process throughout the health service. The Griffiths recommendations argued against consensus management and considered that there was no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. The report therefore recommended the introduction of a new concept, that of general management, into the National Health Service. The consensus style of management which had been introduced in 1974 was abandoned, medical and nursing representatives lost their power of veto on management teams, and the diplomatic style of the pre 1983

administrator/manager was replaced by a new generation of General Managers, who, as the name implies, would be responsible and accountable for the whole of the organisation. The grade of Chief Executive, which had been shunned years before in the Porritt Report of 1962 (Porritt, 1962), and again in the Farquharson-Lang Report of 1966 (Farquharson-Lang, 1966), was established.

The Griffiths Report recommended that the existing multi-professional teams be abolished and the organisation be led by general managers at each level of the service. So far as doctors were concerned, Griffiths envisaged that they would be involved to the extent that they would manage their own and their juniors' clinical activity within a given budget and that they should be provided with administrative support and the information necessary to manage effectively. Griffiths also hoped that some doctors would be appointed as general managers at the hospital and service level. He argued that this was essential because doctors' decisions determine resource allocation (Allsop and Mulcahy, 1996, p17).

In his recommendations, Griffiths spoke of doctors being looked on as "the natural managers." He said:-

"...doctors largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in

securing the most effective use and management of resources. The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers."

(Griffiths, 1983, pp18-19).

In the event, few doctors actually took up general management posts, only 16% of general managers being medically qualified by 1986 (Harrison and Pollitt, 1994). A survey of Units over the period October 1986 - 1987 showed that out of 687 Unit General Managers in post in England and Wales, 54% were previously NHS administrators, 11.2% were doctors, 11.2% were nurses, and the remainder were from outside the health service (Edwards, 1993, p99). Hunter, however, suggests that there was a substantial increase in the number of doctors in general management positions by the early 1990s (Hunter, 1992).

The role of General Managers was stated by Griffiths broadly to be:-

- * Providing the necessary leadership to capitalize on the existing high levels of dedication and expertise amongst the NHS disciplines and to stimulate initiative, urgency and vitality.
- * Bringing about a constant search for major change and cost improvement.
- * Securing proper motivation of staff.
- * Ensuring that the professional functions are effectively geared into the overall objectives and responsibilities of the general management process.

* Making sense of the process of consultation.

(Griffiths, 1983, pp13-14).

Nursing, which from 1974, had been part of the top management process, continued to have a voice in managerial terms following the 1980 Act, as the District Nursing Officer was an equal member of each District Management Team. Nursing failed however to capitalize on its new found higher management profile and despite strong protests from their professional body, The Royal College of Nursing, nursing was the immediate loser, in a managerial sense, in the 1984 reorganisation which followed the Griffiths Report of 1983.

In the opinion of Strong and Robinson, nursing was, "In no fit state to suddenly assume huge professional, financial and managerial responsibilities" (Strong and Robinson, 1990, p19). The opportunity for nursing to be an integral part of top management was lost, although the profession did seize on the Griffiths' emphasis upon the patient in health care and subsequently many senior nurses have been appointed to posts such as director of quality assurance. Their relatively low rate of success in obtaining general management posts however, immediately following the implementation of the Griffiths Report, had not significantly improved by 1987 (Harrison and Pollitt, 1994, p67).

Whilst the pre Griffiths manager lacked power and authority, especially over medical staff, the new order of General Managers/Chief Executives in charge of the whole of the organisation, would, it was expected, correct this by giving them clearer authority. The implications of the Griffiths Report and the effect on the balance of power between general managers and doctors will be discussed in chapter six.

In the next chapter, discussion will take place on changes which were even more radical than those discussed so far. These changes included the milestone White Paper "Working for Patients".

CHAPTER THREE

MANAGE OR BE MANAGED

The previous chapter looked at changes which were sweeping through the health service, all of which had implications for doctors and management. In this chapter I shall discuss attempts by government to involve doctors more in the formal management process leading on to some of the most radical changes ever to be introduced in the health service. As mentioned previously, the (perceived) problems to which these changes tried to respond were in part attributable to the increasing public expectations of a service where resources, especially public resources were limited. These expectations were fuelled by press and TV coverage and as Thwaites explains (see pp69-70) could never realistically be matched. There was also the problem of substantial professional power and autonomy which, according to Salter, the authority of managers could do little to curtail (Salter, 1998, p220).

The Resource Management Initiative.

In an attempt to involve doctors more formally in the management process and following earlier initiatives in management and clinical budgeting, the government, introduced the Resource Management Initiative in 1986. It built on development of the information systems outlined in the previous chapter and was described as:-

- * Stimulating, encouraging and developing a hospital management process involving doctors, nurses and other clinical and managerial staff in strategic and operational policy decision taking.
- * Ensuring that such a process is underpinned by a patient based information system which is timely, accessible and credible to all participants.

(Department of Health and Social Security, 1986a).

In effect the initiative was concerned with the involvement of clinicians, especially doctors, in the planning, implementation, control and monitoring of the use of resources. The RMI was piloted in 6 sites, and was then extended rapidly with all large acute hospitals able to join the initiative by March 1992 (Ham, 1991, p3). This initiative was intended to be instrumental in the emergence of the Clinical Director, one doctor to represent a group of doctors from one specialty, to manage and be accountable for a part of the hospital's resources

as effectively and efficiently as possible (Sutherst and Glascott, 1994, p19).

The emphasis in the RMI was to involve medical and nursing staff much more in the budgetary process in an attempt to plan, deliver and cost patient care more effectively. The three most important aspects of the initiative were to develop a credible database of accurate diagnostic and operational coding, to establish a case-mix management system for recording patient treatment resource usage and costs and to implement effective nurse management systems (Sutherst and Glascott, 1994, p5). Medical audit was a key feature of the RMI, in order to underline the importance of developing ways to measure outcomes of service provision. The government considered that rather than injecting more and more public funds into the Health Service, a better use of resources was possible. The key players in this strategy were medical staff since they were the main spenders of National Health Service money and therefore should be accountable for its use.

With the introduction of the RMI in the period 1986-1992, there was an attempt to integrate the various clinical hierarchies into clinical directorate teams (Riordan, Simpson, 1995, P21). The former "management

budgeting" became resource management with a much greater emphasis on information systems and organisational issues leading to the introduction of case mix planning and costing (Cook, 1995, p93).

The underlying philosophy behind the Resource Management Initiative was that the involvement of clinicians in the management of their hospitals would increase their commitment to the overall objectives and goals of the organisation. With better information systems and accurate information about clinical activities, the quality of care would be enhanced (Butler, 1992, p19). In short, resource management was about a change in attitudes and ways of working as much as the introduction of particular techniques and systems (Coombes, Bloomfield, and Rea, 1991, pp16-17).

Whilst the declared objectives of RMI were to provide information to clinicians to enable them to identify areas of waste, benefit from clinical discussion, identify the health care consequences of given financial policies or constraints and consider future health care options, Brunel researchers suggest that the development of resource management placed greater emphasis on cost as opposed to activity data (Buxton, Packwood and Keen, 1989).

It was argued that the RMI failed on a number of counts. In the opinion of Flynn, the slow, tentative progress of the RMI was due to the fact that doctors were cautious and sceptical for a variety of reasons, believing that resource management compromised their professional ethics and clinical freedom (Flynn, 1992, p185).

Marnoch states that, "The resource management initiative was intended to place resource consuming decisions at the level at which judgement could be exercised - an important idea in the Griffiths Report.....to take decision making down to the level of the individual consultant. In reality the resource management initiative tended to be absorbed into the clinical directorate management process" (Marnoch, 1996, p58). This tended to defeat the objective. Doctors recognised that the resource management objectives were often camouflaged and were suspicious when the initiative was sold as an educational or research tool (Marnoch, 1996, p58). Instead they saw it as an attack on clinical autonomy. In the view of Coombs and Cooper, the RMI had not facilitated the management reorientation intended (Coombs and Cooper, 1990).

National Health Service and Community Care Act 1990

The Griffiths Report of 1983 which introduced General

Management into the Health Service was, as we have seen, a watershed in the way health services would be managed in future. However, so far as doctors were concerned, the effect of the introduction of general management, (see chapter six) was limited. Even their interest in being involved in the management process at that time was not very great. Harrison and his associates observed, quoting a senior hospital doctor, that the idea that many clinicians would be interested in taking on time consuming management posts was, "One of the fallacies of Griffiths" (Harrison et al, 1989, p11).

However, hardly had the Griffiths Reforms been implemented throughout the health service, when another set of reforms, even more radical, were announced in the late 1980s. All of these reforms, as we shall see, had a profound effect on the management of health services and on the evolving role of doctors in management, albeit in an informal and indirect way.

It was as a result of a further financial crisis in 1987/88, that the then Prime Minister, Mrs Thatcher, announced there would be a Prime Minister's Review of the Health Service, after which the government issued a White Paper, "Working for Patients" (Department of Health and others, 1989).

Rather than merely injecting more cash into the service, the government concluded that the organisation of the NHS needed to be radically reformed in order to make more efficient use of *existing* resources. Already in place were the General Management arrangements following the Griffiths Report in 1983. Now it was considered necessary to change the organisational arrangements for the delivery of health services, with competition and market forces as key elements in the strategy. The Government promoted a revolutionary programme of reorganisation and reform throughout the service, incorporating on the supply side, much of the market philosophy and competition outlined at the beginning of the Thatcher era in 1979.

In all, three White Papers were published around this time. They are summarised by Ham:

i) **"Promoting Better Health" (1987)** This was aimed at raising the standards of health and health care in primary care with a greater emphasis on prevention and health promotion and on making GPs more responsive to their patients- eg by encouraging them to produce more information about their practices and by increasing the % of their remuneration which came from capitation fees.

ii) **"Working for Patients" (1989)** This was the outcome of the ministerial review of the NHS. The review was established to address underlying problems in the management and funding of the NHS.

iii) **"Caring for People" (1989)**. "Caring for People" followed a separate Griffiths Report on Community Care, Agenda for Action. It

dealt with Community Care and gave local authorities the lead responsibility in the planning of community care. It also emphasised the purchaser/provider split.

(Ham, 1991, p1).

The first was the beginning of the wrangle over the new GP contract, whilst the latter two White Papers were subsequently embodied into legislation in the National Health Service and Community Care Act 1990. The thinking behind these reforms was that competition and commercial organisational models have a place in public service enterprises.

April 1991 saw the biggest organisational changes ever to be made up to that time in the National Health Service, changes which have had continuing impact on the organisation and management of the service. Implementation of these major reforms began within 2 years of the White Paper, "Working for Patients", and less than one year after the passing of the NHS and Community Care Act 1990, on April 1st 1991.

The "Working for Patients" White Paper proposals outlined a programme of action designed to secure two declared objectives: "to give patients, wherever they live, better health care and greater choice of the services available" and "to produce greater satisfaction

and rewards for NHS staff who successfully respond to local needs and preferences" (Department of Health and others, 1989, p1).

These two objectives however have been argued by many to be more at the level of political rhetoric than action plans. The objectives and the following key measures were, in effect, about breaking up a huge state monopoly, introducing market incentives, trying to reduce the power of the consultants, and decreasing the power of the Trade Unions, all in line with New Right ideology.

The White Paper contained seven key measures:-

- i) **"More delegation of responsibility to local level.** To make the service more responsive to patients' needs, responsibilities will be delegated from Regions to Districts and from Districts to hospitals.
- ii) **Self-governing hospitals.** To encourage a better service to patients, hospitals will be able to apply for a new self governing status, *within* the NHS as NHS Hospital Trusts.
- iii) **New funding arrangements.** To enable hospitals which best meet patients' needs to get the money to do so, the money required to treat patients will be able to cross administrative boundaries.
- iv) **Additional consultants.** To reduce waiting times and improve the quality of the service, 100 new permanent consultant posts will be created over the next three years.
- v) **GP practice budgets** To help the family doctor improve his service to patients, large GP practices will be able to apply for their own NHS budgets to

obtain a defined range of services direct from hospitals.

- vi) **Reformed management bodies.** To improve the effectiveness of NHS management, regional, district and family practitioner management bodies will be reduced in size and reformed on business lines.
- vii) **Better audit arrangements.** To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited."

(Department of Health and others, 1989, p3).

Competition was presented as a way of providing better value for money services, more choice for consumers, and a better service designed to meet the needs of the population well into the next century.

Before the reforms, money voted for the NHS by Parliament was allocated to the Regional Health Authorities who in turn would finance District Health Authorities and Family Health Services Authorities for them to fund their local units, and primary care contractors. This system changed in 1991. The providers of services, now had to win contracts from fundholding GPs and Health Authorities in order to survive (Health Service Journal, 1997, p14).

The "Working for Patients" proposals included the setting up of Trusts whereby hospitals and other provider

units would sell their services to buyers, who in the main would be fundholding General Practitioners and Health Authorities. There would therefore be a market of buyers and sellers with the element of competition being introduced for the first time into the core clinical services of the NHS.

Health Authorities would be able to choose to buy services from a range of providers. In the words of Hunter, "The purchasing role becoming the centre piece of the reforms" (Hunter, 1991, p27). The Health Service was moving further into a business-like mode with market principles, competition, and contracts for services becoming increasingly important factors in its organisation and management. A key point is that Health Authorities were divested of their management responsibilities for health service providers.

The vast changes which were starting to unfold in the new NHS were a result of the shift in financial control, from providers to purchasers in the form of fundholding GPs and Health Authorities, these purchasers in turn being encouraged to be more receptive to the wishes of their patients (Harrison et al, 1989a, p38). Even by 1994 it was estimated that 96p in every pound spent on hospital and community services in England was spent on purchasing

patient services from NHS Trusts (Langlands, 1994, p2). Indeed, such was the expansion of Trusts that by 1997, there were 492 trusts, providing 95% of all health services in the country (Health Service Journal, 1997, p7).

The "new" National Health Service, following the 1989 "Working for Patients" proposals and the 1991 implementation of the Reforms, presented doctors with further dilemmas. The White Paper stressed that hospital consultants, whose decisions about treatment commit substantial sums of money, should be involved in hospital management, given responsibility for the use of resources and encouraged to use these resources more effectively. They should have an appreciation of the philosophy behind the changes resulting from "Working for Patients" (Department of Health, 1989) as well as an understanding of their practical effects (Sutherst and Glascott, 1994, p5). Indeed, applications for Trust status needed to demonstrate the involvement of clinicians in management. In addition, the new arrangements included the very important transfer of Consultant contracts of employment from the Regional Health Authorities to individual Trusts, in effect meaning that medical consultants would now be appointed by, employed by, and paid by, the Trust in which they worked. They were

therefore subject to the personnel and employment practices of the Trust. Not least among the issues was that of job descriptions. Previously the standard consultant contract of employment had been vague as to the duties to be performed (Harrison et al, 1992, p144). Now, backed by the "Working for Patients" White Paper, "Every consultant should have a fuller job description than is commonly the case at present. This will need to cover their responsibility for the quality of their work, their use of resources, the extent of the services they provide for NHS patients and the time they devote to the NHS" (Department of Health and others, 1989, p42). Also, management would now have a say in the merit award system by being present on regional and national committees which respectively nominate individual consultants for awards and make the final decisions (Harrison et al, 1992, p144), with individual Trusts deciding on the allocation of the lowest grade awards. In all these directives a stark choice was emerging for consultants: manage or be managed.

The effect on management of the reforms was substantial. One of the major shifts in power which occurred, and is still occurring, as a direct consequence of the reforms, was that which changed the relationship between General Medical Practitioners and hospital

Consultant specialists. This will be discussed later in this thesis (see chapter 5).

So revolutionary were the reforms and their impact on the very notion of a National Health Service, it is important to examine if the introduction of the internal market, the cornerstone of the reforms, was consistent with the basic principles of the health service, since the basic principles of equity and access fundamentally influence the management style and organisation of the NHS.

The Basic Principles

The basic principles of the National Health Service were that services were to be comprehensive in provision and universal in population coverage (Leathard, 1990, p29). All health services were to be free of charge at the point of use, and expenditure was to be financed mainly from general taxation.

The National Health Service started out with three operational objectives:-

- i) The adequate and public financing of services.
- ii) National control of their distribution.
- iii) Appropriate planning and co-ordination of

workloads and service delivery based on
an effective doctor patient relationship.

(Leathard, 1990, p29).

Aneurin Bevan, when presenting the National Health Service Bill to Parliament on 30th April 1946, stated that the intention was to divorce the ability to get the best health service advice and treatment from the ability to pay. The Health Service was designed to meet health (or more accurately, medical needs) wherever and whenever they arose (Leathard, 1990, p30). This was a factor in the considerable power of doctors as they had the expertise to define and prioritise "medical need". The basic principles were laid down and enacted in legislation in The National Health Service Act 1946. The question is, whether or not the "Working for Patients" reforms, in particular those aspects of the reforms which introduced the internal market, accord with these principles, or whether they challenge them, with corresponding implications for doctors?

The Internal Market

So why was the idea of a market philosophy for the NHS felt to be necessary at all? One of the main problems which has dogged the NHS since its inception, if not the main problem, has always been a perceived shortage of financial resources. Repeated attempts have been made

over the years to overcome this problem, but for a number of reasons these have met with little success.

As stated earlier, one of the main Ministerial Review conclusions preceding the "Working for Patients" White Paper was that repeatedly putting more money into the health system was not the way forward. Major changes in philosophy were needed, the emphasis was to be on competition and marketing to bring about increased efficiency in the way resources are used. Already at that time the far-reaching General Management arrangements were well under way following the implementation of the Griffiths Report (1983). The intention was to build onto the management reforms which were designed to give managers more power and authority at the local level, to make them more pro-active, yet more accountable, and, because of the nature of their fixed term contracts of employment, to allow central government more control over managerial activities, especially with regard to finance. In an article (in 1985) on incentives to efficiency in health services management in the U.K. Enthoven had the notion that a system of internal markets in the NHS would produce greater efficiency and improve services which in turn would lead to better value for money. (Enthoven, 1985). Internal markets would later become one of the key

proposals in the 1989 White Paper "Working for Patients" (Department of Health, 1989).

In a foreword to the 1989 White Paper "Working for Patients" (Department of Health, 1989) the then Prime Minister, Mrs Thatcher, stated that:-

"The National Health Service will continue to be available to all, regardless of income and be financed mainly out of general taxation ...while maintaining the principles on which it was founded and to prepare for the needs of the future."

(Department of Health, 1989).

The original principle of free of charge at the point of use, had long since been abandoned, with prescription charges having been introduced in 1951 and increased numerous times since then, and other charges introduced ie for dental treatment, eye tests etc. (charges which in total however only amount to some 3% of total National Health Service income (Appleby, 1996/97, p74), with widespread exemptions from charges for certain categories of people). However, it would seem that the proposals contained in the White Paper were to be consistent with the other basic principles. According to Ham, "The Government has emphasized that the basic principles on which the National Health Service was founded are not affected by the reforms. Health services will continue to be available to all, irrespective of

means, on the basis of need. Also, most services will be provided free at the point of use" (Ham, 1991a).

The internal market, proposed for the National Health Service in the "Working for Patients" White Paper however, gave "official blessing to the concept of the efficiency-seeking, self-governing hospital and to competition, both in primary and secondary care for patients" (Harrison et al, 1990, p20). The intention of this buying and selling was to put hospitals and other provider units under competitive pressure to improve the quality and efficiency of services for patients. In effect the market was to be used as a tool to create these outcomes. However, this was to be a "managed market", the new market for NHS health care would take a rather special form with regulation being the key. "The role of the NHS Board and of regions would no longer be to plan and integrate services but to monitor and regulate standards" (Strong and Robinson, 1990, p185).

Enthoven considered that each district would resemble a nationalized company with competition between hospitals. It would buy and sell services from one district to another and trade with the private sector (Enthoven, 1985, p3). This trading would be on a formal contracting basis. Such an internal market, he considered, would

still meet all the social objectives of the National Health Service, in particular free comprehensive care for all U.K. citizens (Enthoven, 1985, p42). The theory was that managers would have incentives to use resources more efficiently and in so doing obtain better value for money and an improvement in services to patients. "There is nothing like a competitive market to motivate quality and economy of service" (Enthoven, 1985, p42).

However, a market system, in the view of Ham, "Means high risk for the National Health Service. This high risk market mechanism which the Conservative Government has embarked on means that the benefits or otherwise would take years rather than months to evaluate" (Ham, 1992). Competition in health care puts doctors in competition with each other rather than co-operating with each other. Evidence existed to suggest hospitals which hitherto had pooled their resources, no longer did so because one hospital is in direct competition with the other. Fund holding GPs had an incentive to favour younger healthier patients at the expense of those who are older and those who are more prone to sickness. There were fears that it would cause some GPs to refuse appropriate referral to hospital on financial rather than clinical grounds (Ham, 1991, p6). However, not much evidence emerged to suggest that these things happened.

It could also be argued that the internal market create a two tier system of health care. Whilst the two tier argument was usually used to compare the patients of fund-holding and non fund-holding GPs, it could also refer to a system whereby those who can afford to pay for private treatment obtained such treatment quickly, whilst others less financially able, and perhaps more in need of treatment, are forced to wait until their purchaser has sufficient funds to pay for their health care. Whilst there is nothing new in this latter point since this has for a long time been one of the chief attractions of the private sector, the new arrangements focused more public interest on this aspect of the reforms.

Enthoven, however in his support for an internal market system for the National Health Service argued that the goals of such a market are:-

- i) Better care that produces better outcomes for patients.
- ii) Better access.
- iii) Greater patient satisfaction.
- iv) Less costly care so that there can be more of it.
- v) More responsive care within inevitably limited resources.

(Enthoven, 1991, p30).

The means of achieving these goals are,

accountability, competition and innovation (Enthoven, 1991, p30). It is perhaps the element of competition which presented the highest risk of the internal market. Competition depends partly on supply and demand but also on political will. If the market was allowed to develop strictly in the way a commercial market operates then the problems, some of which have been highlighted in this chapter, would continue to manifest themselves and raise doubts about the reforms and whether the basic principles of the National Health Service are at risk. On the other hand, was it possible to have a "managed" market, or does it cease to be a market if it is managed politically?

In the view of Hunter and Webster, writing a year after the Reforms were introduced, "The 1989 White Paper launched the National Health Service into a dangerous experiment which has effectively destabilised the whole edifice. If allowed to run their natural course, the reforms are likely to turn the clock back to the situation existing before the second world war, precisely the chaotic system the National Health Service was created to supplant" (Hunter, Webster, 1992, p26).

It is clear there are considerable differences of opinion on whether or not the internal market, as embodied in the reforms, was consistent with the basic principles

of the National Health Service. Ham suggested that significant benefits could be achieved, but less through competition and more through the purchaser/provider split and the use of contracts to hold providers more accountable for developing explicit standards that are specified by purchasers (Ham, 1991b, p7). This approach, Ham hoped, would prepare the National Health Service for the future whilst still maintaining the basic principles of equity and access of the past.

The position of doctors in management during this period was still that of a powerful dominant interest, always involved, always exerting influence, but never formally accountable for their actions, other than for clinical matters. However, it could be argued that this informal dominance which the medical profession had relied on for so long, had now begun to falter. It had unsuccessfully resisted the new GP contract (see chapter 5) and it had failed to prevent the 1991 reforms which it so bitterly opposed. The reality of these failures was fast dawning on the medical profession and they increasingly recognised that informal dominance was no longer strong enough to prevent changes they were opposed to, no longer strong enough to impose the medical profession's point of view on discussions and decision making relating to major issues.

It will be argued (see pp220-221) that the Griffiths inspired introduction of general management failed to significantly challenge medical power. This situation prevailed before and indeed after the Griffiths proposals had been implemented. It was not until the financial constraints of the early 1990s and the operation of market forces began to have an effect, that many hospital consultant medical staff began to seriously consider their position regarding formal involvement in the management process. A variety of evidence, such as the explosion of literature on doctors in management, the creation of an association for doctors in management, The British Association of Medical Managers, (BAMM), the increased participation of doctors in management development programmes, as well as the findings of my fieldwork research (see chapter 7 pp272-273) all suggest that doctors considered it was time they became formally involved. As one Medical Director interviewed said:-

"The NHS was slipping away with the emphasis on the wrong things. We have to get involved not only to stop this but to get the service back on course so that the treatment and care of patients once again becomes important."

(Consultant Physician, Medical Director).

Medical/Clinical Audit

Medical Audit, according to Marnoch, was established as a basic principle in primary care in the 1970s, with

GPs participating on a voluntary basis (Marnoch, 1996, p33). However it is in secondary care, where medical audit became a contractual requirement for consultants after 1989 (Department of Health, 1989, p30), which will be explored here, since it is an important development in the evolving role of doctors in management - as well as in the evolving management of medicine.

The 1989 White Paper, "Working for Patients", placed great emphasis on the need for medical audit to be carried out in order to assess clinical practice. However, the concept of audit was by no means new for the Health Service. Various schemes such as Clinical Budgeting, Resource Management, Performance Indicators, all involved types of audit.

The Government gave a clear definition of audit in Working Paper No. 6 of "Working for Patients," in which it stated that:-

"Audit is the systematic, critical analysis of the quality of medical care including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient."

(Department of Health, 1989b).

Prior to the reforms, there was scant literature on audit as it applied to direct patient care (Packwood,

Kerrison, Buxton, 1992a, pp192-196). It could well have been a function of managers to determine the audit programme and implement the findings, however the particular model of medical audit introduced after 1991 did, it has been argued, leave doctors "in charge", with the result that doctors, who would be crucial to the successful implementation of any audit programme designed to improve patient care, needed to be trained in the skills necessary for the organisation of the structure and process of audit. According to Kerrison, Packwood and Buxton, doctors would have to determine who would be included, who would carry out the work, and, perhaps most importantly, what would happen to the results (Kerrison et al 1994, p155).

The various Royal Colleges all produced policy statements affirming their commitment to medical audit, and their view of the purpose to which audit would be put. They saw the purpose of Medical Audit in a variety of ways, for example the Royal College of Anaesthetists saw it as a means of gathering information which should produce improvements in patient care, to develop more effective training of junior staff and to ensure that capital and revenue expenditure was used effectively (Amess, Walshe, Shaw, Coles, 1995, p23).



The Royal College of Physicians saw Medical Audit as essentially an educational tool to enable evaluation of selected case records in order to highlight deficiencies in records and practice and suggest ways of improving outcome. The predominant purpose was to improve patient care. It should also be used to identify procedures that waste time and resources (Amess et al, 1995, p23).

The Royal College of Surgeons viewed audit as a means to encourage change and improvement in clinical practice. It provided peer support for individual clinicians, was an important educational process for both seniors and juniors and raised the overall quality of patient care in a department (Amess et al, 1995, p24).

The Royal College of Psychiatrists, which preferred to use the term "clinical audit" (after about 1993, this was the accepted term and the scope of audit extended beyond just the medical aspects of care) saw audit as a means of identifying the effectiveness of specific treatment regimes, for evaluation of cases, and for an examination of the occurrences of unusual but undesirable events. In addition, it could be used to provide statistics for financial planning and accounting (Amess et al, 1995, p23).

The government funding allotted to Medical Audit, around £160m up to 1994 (Department of Health, 1993, p6), was distributed via regional and local audit committees whose membership was composed purely of clinicians, thereby allowing the medical profession an opportunity to decide who should take part in the process and who should have access to the results. There was no formal organisational link to the Total Quality Management programme which many NHS senior managers were running at the same time. Instead it was the expectation that change would come about by virtue of the increased knowledge and additional information which medical audit afforded to doctors themselves.

Whilst it was the intention that managers would be heavily involved in overseeing medical audit, the reality was that the management input was very weak, primarily because of the confidential nature of many of the medical audit processes together with the funding arrangements which gave the medical profession a definite ownership of medical audit. Indeed in the words of Kerrison, Packwood, and Buxton, audit was seen as "An extension of the profession's current self management arrangements" (Kerrison et al, 1994, p157).

Kerrison and colleagues carried out a case study of

the implementation of audit in general medicine at four hospital sites in the early 1990s. Their research, which was based on observation of specialty audit meetings and local audit committee meetings including interviews with key players ie clinicians, audit co-ordinators, junior hospital doctors, ward sisters, nurses, local hospital managers (Kerrison et al, 1994, p160), concluded that the audit process was planned by lead clinicians of the various specialties who chose the topics for audit, although junior doctors were also encouraged to do so. They found that although the audit meetings were often attended by other health professionals the dominant group was always consultant physicians and their juniors. Medical Audit, according to the Kerrison et al study, emerged as almost the exclusive domain of the medical profession who were hostile to the introduction of audit, suspicious of government motives, fearful of the time commitment and unconvinced about its benefits. The audit criteria concentrated on the technical aspects of care with little evidence of any assessment of resource use. There was uncertainty as to what would happen to the audit result and it was rare for proposals to be followed up. The overriding conclusion from the study was that one of the main purposes of medical audit is for the self management of the medical profession (Kerrison et al, 1994, pp159-167) rather than a management tool to control the

medical profession. The weakness of the management input in overseeing of conformance to standards can be attributed to a number of factors, not least the very technical nature of many medical audits which, enables doctors to call into question the contribution the non medical manager can make in these circumstances.

According to Day and Klein, a key management activity is the exercise of accountability (Day and Klein, 1987). There must be agreement between those who are required to meet standards, possibly standards determined as a result of the audit process, and those who have oversight over the standards or yardsticks used to measure performance. The theory is that management will be able, through the audit process, to exercise the mechanism of conformance to standards. This however leaves unresolved the problem of accountability when those in formal management positions are not recognised as being legitimately the doctor's manager. Even within the medical profession the lines of accountability are blurred between a consultant of one specialty and another, indeed often between consultants of the same specialty. This accountability has been made more complex, although it remains important, by the breakdown of the traditional firm; so that junior doctors increasingly work for a number of consultants.

With these difficulties of accountability at operational level, Kerrison et al (1994) suggested that a practical solution may well be for the Royal Colleges to be more involved in developing audit formally as a process of educational or professional development. The Royal Colleges have the means of compliance available to them in the form of educational approval of training posts, which are reviewed every five years or shorter period if considered necessary, research grants, merit awards etc. Thus action can be taken by the Royal Colleges to reward or sanction their members to ensure conformance to standards - keeping it in medical hands, but with a power shift from individual to group.

The transformation of information obtained through the medical audit process into management information remains a matter of debate in many hospitals (Scott, Jackson, 1995, p150). The clear implication of medical audit is that management, in particular non medical management, will obtain an insight into and a measure of clinical practice and as a result may initiate measures which involve change in the working practices of doctors. The resistance to this potential inroad into the jealously guarded domain of doctors' clinical autonomy is a major obstacle to the implementation of changes designed to

overcome the deficiencies highlighted by the audit process.

One answer to this difficult question seems to be, as most of the policy statements from the Royal Colleges allude to, a better agreed understanding of the purpose of medical audit. A degree of trust and co-operation needs to be developed between doctors and managers. Managers must built up a credibility with their medical colleagues if they want plans designed to change the working practices of doctors to succeed. In the small, compact NHS Trusts, the directorate and sub directorate management groups and the audit group, through common membership, facilitate the sharing of knowledge of changes in practice. The small number of consultants and other staff involved also make these processes very informal.

The relationship of audit with issues around doctors and managers, doctors in management and around shifts in the power of doctors is extremely important. Audit has the potential to shift autonomy from individual doctors to the greater power of the collectivity of doctors (at Trust level and Royal College level) and thus greatly influence individual practice and the use of clinical resources but as it has been introduced in the NHS, doesn't appear to have been of major significance in shifting power from

doctors to managers. The question could be asked, would it have been any different if more doctors were managers?

Since the introduction of compulsory Medical Audit brought about by the 1989 White Paper, the policy and practice of Medical Audit have changed significantly. Policies and attitudes to audit have developed, audit in its wider sense has taken root in all the health care professions. It is increasingly recognised that the care of patients involves the combined efforts of a number of other professions and it is necessary for new approaches to audit to reflect this. For example from about 1993 there was a move from medical audit to clinical audit, i.e. towards multi professional audit, and there is a developing role and growing involvement of healthcare purchasing authorities in audit which has important implications. In July 1993 the Department published a policy document, "Clinical Audit: Meeting and Improving Standards in Healthcare", which sets out a strategy for moving towards multi-professional clinical audit with an emphasis on "clear definitions and quality and outcome of healthcare" (Calman and Moores, 1994, p1). It was suggested that indicators of the successful development of audit are that it is undertaken by multi-professional healthcare teams, it is focused on the patient, and it develops a culture of continuing evaluation and

improvement of clinical effectiveness of patient outcomes (Department of Health, 1994, pp7-9).

Clinical Audit has been defined as the systematic and critical analysis of the quality of clinical care, including the procedures used for the diagnosis, treatment and care, the associated use of resources and the resultant outcome and quality of life for the patient (Department of Health, 1993). There is also increasing interest in health care outcomes assessment and its links to audit (Amess et al, 1995, p25). The move from medical audit to clinical audit was seen as a natural progression of the audit process, it was a recognition that it was important to involve other clinical professionals.

The dilemma for managers in carrying out audit procedures however, as they apply to clinical areas, is that one important motive is to enable managers to gain an insight into the hidden (and costly) world of clinical practice in order to effect change and attempt to create financial efficiencies in this area. This clashes with the useful educational aspects of audit and probably is the main reason why audit programmes have been slow to gather momentum and effect change and indeed poses the question, whose interests are being served by audit, the doctors or the managers?

Audit also again raises the question of the divide between power and authority. The manager with the formal authority should be able to utilise the tool of audit to identify good and bad clinical practice where this exists, and to take appropriate action. The manager's lack of power over consultant medical staff prevents him/her from doing so. The shift in power from the individual doctor to the collectivity of doctors which the audit process can bring about, makes it even more unlikely that the lay manager will be able to break into the closed world of clinical performance. This adds fuel to the argument that power and authority need to be brought together in order to effect change in clinical practice. Audit is also a good example of the ability of the medical profession to adapt to changed circumstances in order to protect its interests. Audit, which was designed as a control tool to curb their individual power, has been turned into a shield to enhance their collective power.

The particular relevance of medical/clinical audit (and indeed of the other information systems mentioned in the previous chapter) for doctors in management is that the data from all these systems, not least a medical/clinical audit system, enable the measurement of clinical performance. To obtain these data is difficult enough, to do something with the data frequently means

infringing clinical autonomy, which, as always, presents major problems. The 1989 White Paper, "Working for Patients", recognised these problems but stated quite firmly that in order to maximise resources and achieve high quality clinical services it was essential to have a comprehensive system of medical audit to cover primary care, community health services and the hospital sector (Flynn, 1992, p88).

Medical/Clinical Audit has not substantially increased the power of management, the speculation that audit would be one way of exerting managerial control over medical staff has not, according to Kerrison et al, been realised (Kerrison et al, 1994 p159). What it has done is shift the power and autonomy from the individual doctors to the collectivity of doctors on audit committees who see audit as an educational tool pointing the way to enhancing clinical performance, especially for doctors in training. The multi-disciplinary nature of clinical audit should open up medical practice to wider scrutiny e.g. from nurses who might also see it as a good educational tool. The dilemma for management is that they see audit as a control tool to ensure that clinicians are using resources efficiently and effectively as possible as well as a tool to measure quality. This is one of the dilemmas of medical/clinical audit, the

educational versus control versus quality issue. Back to the question, whose purpose is audit serving: is it the medical profession with its use of the tool to enhance clinical performance, educate individuals and strengthen professional standards, or is it management to improve quality and a more cost effective use of resources? Whilst these differing objectives are not necessarily incompatible, doctors are still suspicious (which militates against compatibility) that behind managerial inspired audit programmes there is an attempt to control medical staff. In the opinion of one of my doctor respondents, "If it (audit) is used to manipulate doctors it becomes suspect." (Consultant Physician, Medical Director).

Evidence Based Medicine

Another area of change especially relevant for the evolving role of doctors in management is the advent of Evidence Based Medicine (EBM). Both audit and evidence based medicine raise questions about the knowledge base of medicine, the relationship between science and clinical judgement, the autonomy of individual doctors, the power of the medical profession and the opening up of information about medicine and clinical practice and performance to non-medical audiences. At least until recently, not so clearly a government initiative as audit,

evidence based medicine is more an inevitable development in an age of rapid technological development. Nevertheless it is a development which has profound potential implications and is a significant challenge to the way doctors have traditionally made clinical decisions.

The term, more broadly expressed as "evidence-based clinical practice" or "evidence based health care", is founded on the aspiration that doctors and other clinical professionals should pursue their work of diagnosing medical conditions and then deciding on the appropriate treatment and care by drawing on the evidence of science and research (Long and Harrison, 1995, p1). This departure from the traditional predominant methods of individual judgement, based on opinions, past experience and precedent is a recognition of the rapid development of medical technology which requires new thinking and new methods and procedures which are known, through research, to be effective. Rosenberg and Donald define evidence-based medicine as, "The process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions" (Rosenberg and Donald, 1995, pp1122-26).

The origins of EBM.

Although not a new concept, since evidence-based

medicine was featured in Cochrane's lecture, "Effectiveness and Efficiency: random reflections on health services" published in 1972, the quest by purchasers for evidence on the effectiveness of procedures which would influence their purchasing strategies has caused the evidence based approach to gather momentum in the late 1980s and 1990s to such an extent that evidence based purchasing, although not very evident in practice up till now, has been argued to have become *the* central health service policy. Indeed there is now a National Health Service Executive requirement for health authorities, "To identify priority purchases and service disinvestments on the basis of, respectively, their effectiveness and ineffectiveness" (Long and Harrison, 1995, p1).

For health service managers in general, including the doctor in management either as a Medical or Clinical Director, the development of Evidence Based Medicine can provide a powerful tool in decision making and in trying to change the clinical practice of consultants. In the opinion of Sackett, Richardson, Rosenberg and Haynes,

"The practice of Evidence Based Medicine requires the integration of individual expertise with the best available external clinical evidence from systematic research."

(Sackett et al, 1997).

The doctor manager who adopts this integrated approach is more likely to achieve desirable changes in clinical practice which hitherto had not been possible. Sackett et al report "That previous work within secondary care has highlighted the value of integrating audit with research, medical education and the library function in getting research into practice" (Sackett et al, 1997).

Evidence based health care is aimed at bringing together the best current evidence from research findings, but then linking it to the individual clinician's judgement about the appropriateness of the evidence for the individual patient (Stocking, 1996, p3). Thus it does not rule out clinical judgement, but puts a constraint on it. "The art and science of medicine must come together" (Stocking, 1996, p3). For doctors the evidence based approach should be seen as a supplement to, and not a replacement for, their clinical judgement. The reality however is that if evidence based medicine gains a strong foothold, doctors will be under increasing pressure to justify their clinical decisions and actions if the decision is contrary to what the research evidence may suggest. This is a worrying aspect for doctors since many argue that medicine, in the words of one of my research informants, "Is'nt like that" (see chapter 8, p321).

As Long and Harrison point out, evidence-based medicine and evidence-based purchasing are far from straightforward. They require the condition itself and the process of care to be defined in as much detail as possible. There are many kinds of clinical procedures for which it is not possible to design a research method or research instrument. For example the randomised control trial, a much used method in medical treatment research, is limited in its scope for generalisation. Findings are restricted to the narrow population which met the eligibility criteria for the original study. "There is an important distinction in health services research between the efficacy (does it work in this controlled setting?) and effectiveness (does it work in routine practice?)" (Long and Harrison, 1995, p2).

One of the main problems they argue, is in the potential misuse of evidence-based approaches, the common misuse of the term "cost effectiveness" when what is really meant is "cost consequences". In addition whilst evidence-based medicine holds great promise for the practice of health care and the quality of care delivered to patients, it ought not to invalidate the role of clinical judgement (Long and Harrison, 1995, p2). In the opinion of Hunter, "Medicine is a highly uncertain and messy endeavour. Evidence-based medicine cannot be

isolated, as it largely has been, from its social, organisational and political setting. Unless we understand how doctors use evidence and how they presently make decisions it is unlikely that simply providing information to them on how to do things differently, or not at all, will succeed" (Hunter, 1996/97, p155).

The goal of evidence-based practice is certainly worth exploring, however the complexities of installing such a system are immense, far beyond the mere writing of guidelines in contracts between purchasers and providers. The implementation of such a system of evidence-based medicine requires a virtual cultural revolution in clinical decision making to the extent that whether it can be achieved at all is questionable. In the view of Long and Harrison, "It is unlikely that professional clinical practice can ever become the narrowly rationalistic process that some proponents of evidence-based medicine might wish" (Long and Harrison, 1995, p11). In addition, no account is taken in the evidence based approach of political decisions taken at national and local level which override any emphasis that science and research might otherwise suggest in the treatment and health care of patients.

An important consideration for managers is whether or

not evidence-based medicine provides the means whereby clinical efficiency and effectiveness can be questioned and changes made to clinical practice (and spending patterns) when the evidence suggests that changes should be made. This comes back to the argument I have maintained throughout this thesis relating to power and authority i.e. has the lay manager (who has the authority) sufficient power to change clinical practice even when he/she has the evidence to support such changes? Can a lay manager bring about these evidence based changes or is the doctor manager eg a Medical Director or Clinical Director (who has power and authority) better placed to do so?

Health of the Nation

A major government initiative was announced in June 1991 with the publication of a Green Paper, entitled Health of the Nation (Department of Health, 1991). This was an indication of the government's intention to move away from a medical care strategy to a health strategy. This thinking had significant implications for doctors, it marked the initiation of a health strategy as opposed to a medical care strategy with a possible diminution in the role, prestige, status and importance of doctors. Given growing acceptance of the evidence that health depends very little on medicine, (Calman, 1993)

doctors could be seen as less relevant to a public policy or even a health service which was really about health.

Following consultation, in June 1992 the Government launched The Health of the Nation strategy. It had the declared twin aims of improving health, and improving the quality of life. The Government identified five key areas where it perceived the need and scope for improvement was greatest:-

- i) Coronary heart disease and stroke
- ii) Cancers
- iii) Accidents
- iv) Mental illness
- v) HIV, AIDS and sexual health

(NHS Management Executive, 1992a, p1).

A series of targets, specific to each of the five key areas would provide a sense of direction which the government hoped was the beginning of new ways in which we can add "years to life and life to years" (NHS Management Executive, 1992a, p1). This element of target setting in the Health of the Nation strategy should, it was argued, enable all concerned to focus their efforts on common objectives and provide a yardstick for measuring achievement (NHS Management Executive, 1992a, p2).

Despite the predominantly curative emphasis of its services, the health service was seen as having a central

role in the strategy, being uniquely placed, it was argued, to contribute to the drive for health promotion as well as treating patients already suffering from illness or disease. The NHS was encouraged to form "healthy alliances" with local authorities, GPs, industry, employers, staff organisations, voluntary groups etc. The key areas to success were identified as being the primary care services and community services (NHS Management Executive, 1992a, p2). The primary objectives were successful health outcomes and high quality of care.

Clearly The Health of the Nation initiative had both direct and indirect implications for NHS doctors, including their role in management. The Government's Chief Medical Officer, Dr Kenneth Calman, said of The Health of the Nation that it represented;

"...the first coherent strategy for reducing avoidable illness in this country. But it has done much more than that. It is revolutionising the way people think about health issues as the debate shifts from how best we can treat disease to how we can prevent it."

(Calman, 1993, p7).

The chairman of the British Medical Association, Sandy Macara, said:

"The BMA welcomes the progress of The Health of the Nation, and in particular the involvement of other Government departments in the initiative. The BMA recognises the

important role of the medical professions in the success of this national strategy for health and looks forward to continuing constructive dialogue and action with Government departments."

(Macara, 1993, P7).

This was the rhetoric, the reality was that it was now the government laying down policy priorities for healthcare, which altered the balance of power between sectors of the medical profession e.g. public health doctors and, to a lesser extent, GPs have a higher profile relative to hospital doctors.

Whilst the policy of The Health of the Nation remained in force, the impetus of the initiative diminished in the years leading up to the general election in 1997. It had failed to reach its full potential, had failed to change spending priorities and was argued to have made little impact on health authorities, acute trusts or GPs'. The major flaws were seen to be "lack of management guidance, and incentives at local level." (McIntosh, 1998, p3).

The newly elected Labour Government, on taking up office in May 1997, immediately added a new thrust and direction to the strategy of a healthier nation by appointing, "A New Minister for Public Health, a position without precedent in British central government" (Hunter,

1997, p24). The new minister for public health, Tessa Jowell, is in the opinion of Hunter, "The cornerstone of the health policy that must embrace the work and priorities of the Department of Health and NHS Executive, not to mention the development of and impact of health related policies coming out of other government departments" (Hunter, 1997, p24). In the opinion of Hunter, the criterion for the success of the new minister for public health will be the impact she makes on all aspects of health policy, including developments in the NHS with regard to hospital and community trusts and primary healthcare practitioners (Hunter, 1997, p4).

Shortly after taking up her appointment, the new minister argued that the Health of the Nation strategy only played lip service to collaboration across government and that it ignored health inequalities as well as focusing on diseases and services, thus casting the burden back onto the NHS. The strategy was thus to be replaced by a more wide ranging health programme. (Jowell, 1997, p5). The rationale for the government's new consultative Green Paper on public health for England "Our Healthier Nation", is that "Poor people are ill more often and die sooner" therefore the new strategy aims not only to increase overall life expectancy and illness-free years for the population as a whole, but also to improve the

health of the worst off relative to the rest of the population. (Reid, 1997, p21).

As the strategy of "Our Healthier Nation" moves away from a medical, curative model for the NHS, a strategy which was apparent in the previous "Health of the Nation" initiative, the new initiative "Our Healthier Nation", focuses more on social inequalities, poor housing, poor life styles, etc. The logic of this is that doctors as a whole, but especially hospital doctors, have a less central role. Would the power of doctors be dissipated? How far will doctors be successful in finding new roles and new forms of power, including a larger role in the management of health services?

The Patients Charter

In 1991 "The Patients Charter" was launched (Department of Health, 1991a). A copy of this Charter was sent to all citizens. The Patients Charter was regarded by the government as a central part of the programme to improve and modernise the delivery of health services to the public, an attempt to increase the power of service users by specifying a range of "rights" to which they were entitled. The fundamental founding principles of the National Health Service, i.e. equity and

access, were reaffirmed in the Charter. In addition the Charter includes non-clinical standards of service, ie respect for dignity, privacy, cultural beliefs, information to patients themselves and, if the patient wishes, information to relatives and friends about the progress of treatment. Also, patients are entitled to know about progress of their treatment, are entitled to specific out-patient clinic appointment times, no cancellation of operation on the day they are due to arrive in hospital, a named nurse, midwife or health visitor, and to a decision made about any continuing health or social care needs before being discharged from hospital. These standards were to be regarded as aims which the National Health Service would be trying to achieve; it was acknowledged that not all providers would reach these standards immediately.

In January 1995 the government issued a new expanded and updated Charter in which it introduced new standards in more areas and improved waiting time guarantees including setting a national standard for waiting for a first appointment as an outpatient (Department of Health, 1995, p3). Whilst it could be argued that the Charter was designed to enhance patients' rights, in reality it is more likely to be useful to managers looking for standards to help negotiations and the contracting process (Marnoch,

1996, p84). Indeed, it could be seen as another element in the shift towards greater control of the work of doctors, for example in their management of their waiting lists.

The Shift to Community Care

Other major changes affecting social policy were also taking place. There was a shift from hospital care to a much greater emphasis on Community Care, which had an effect on the number of hospital beds consultants had at their disposal in the treatment of their patients. The number of people admitted however went up, because length of stay went down. There was a massive expansion in private nursing homes and residential homes with large numbers of elderly persons being discharged from long stay geriatric hospitals into these private nursing and residential homes. The number of places in these homes (owned both by for profit and voluntary organisations) rose from 107,000 in 1980 to 318,000 by 1990 (Laing, 1994).

This huge growth meant that places in private and voluntary nursing homes almost trebled between 1984 and 1989 compared with a mere 20% increase in the previous six years. Also, between 1984 to 1989, private residential home places also trebled after a similar low rise in the

previous six years (Appleby, 1992, p54). In the 1980s over 40% of this sector's revenue was funded by the Department of Social Security, in the form of Income Support, the remaining 60% from direct payment by the users of private long term care services or their relatives (Appleby, 1992, p55). There was also a huge shift in the number of mentally ill patients from psychiatric hospitals following the decision to close down many of the long stay mental hospitals in an attempt to reduce admissions and to return large numbers of patients, including some with severe and enduring mental illness, back into the community.

Private Finance Initiative

The Private Finance Initiative was launched by the government in 1992 in an attempt to involve the private sector more in the funding of capital developments in the health services (Dix, 1996, p1). This initiative would have short and long term implications for managers and doctors because it added a new dimension to the control aspects of health services organisation and management and to the debate on power and authority which I shall be discussing throughout this thesis. Once private sector firms invest huge capital sums in health services provision, they will undoubtedly want to be involved in decisions regarding the "running of the business" as they

see it. The implications of this for managers and the evolving role of doctors in management will be discussed in this section.

From 1992, the government began to actively encourage private sector finance for major capital schemes in the National Health Service and was prepared to delay these projects until it was satisfied that all avenues had been explored for bringing in private sector finance before allowing public funds to be committed.

Managers have long been encouraged to pursue joint ventures between the public and private sectors, even from the start of the Conservative Government's first term in office in 1979, the competitive tendering programme being a good example of this (Department of Health and Social Security, 1983a). However, a number of constraints, primarily because of the tangle of regulations, prevented Health Authorities having access to private capital markets. The White Paper, "Working for Patients", 1989, eased many of these constraints, particularly for NHS Trusts which are now allowed access to private capital markets, freedom to set their own wage levels and to use surpluses as they see fit (Bach, 1990, p22). In addition, The National Health Service (Residual Liabilities) Act, passed in 1997, closed a legal loophole

which had threatened to undermine the Private Finance Initiative. Prior to the new Act, if a trust or health authority got into financial or other difficulties which could result in its being wound up, the creditors would have no means of recovering their money. The National Health Service and Community Care Act of 1990 gave the Health Secretary merely "discretion" to pick up the debts (Crail, 1996, p4).

The new Act, removed the discretion and placed a "duty" on the Health Secretary, that if a National Health Service trust or health authority ceased to exist, "To ensure all its liabilities are dealt with" (White, 1996, p22). It removed a major obstacle to the Private Finance Initiative.

The Labour Government (which in opposition had opposed the PFI as "backdoor privatisation") announced, on taking up office in 1997 that the initiative needed to be invigorated. Defending the Government against accusations of "glaring hypocrisy" (Womack, 1997, p9), Health Minister, Alan Milburn said, "When there is a limited amount of public sector capital available, as there is, it's PFI or bust" (Milburn, 1997c, p7).

There seems little doubt that the way forward with

regard to financing major schemes in the future is seen to be with a mix of public and private finance. Without a detailed exploration of the availability of private finance, future capital schemes will not now be considered. Whilst privately funded schemes for even small projects are good news for a government looking at ways to involve the private sector more in the funding of the National Health Service and thus reduce public borrowing (though not necessarily, public spending), the real goal for the government is new-build district general hospitals, and other substantial capital schemes, funded from private sources for the life cycle of the project of between 25 to 40 years (Lyons, 1995, p1).

For managers, these schemes are adding considerably to their already heavy workload. For doctors in management or intending to become actively involved in management it will become increasingly important for them to understand the PFI process. The PFI is not just about borrowing money from the private sector. This cannot make financial sense because interest rates will always be higher than those for public sector borrowing. In order for PFI projects to work, the private partners also need to be involved in providing services, thus producing a revenue stream and taking some of the "risks." It is the provision of services that most clearly raises issues of

control. Indeed there could be an argument to support the view that large PFI schemes where the private partners manage the estate, the non clinical staff, and the majority of non clinical services, leave precious little for the lay manager to "manage." This could have the potential to reduce the role of the lay manager to a monitoring role, thus enhancing the role of the doctor manager as the services still in public hands will be those involving clinical/medical expertise.

Clearly the Private Finance Initiative has a multitude of managerial and financial issues to consider and resolve. Lyons states that, "Questions for professional health services managers include the prospect of construction companies in consortia taking over the operation of a trust hospital, or at the very least, having representation on the trust board" (Lyons, 1995, p1).

The implications of the PFI for doctors has caused considerable concern for their professional associations, the British Medical Association, and the NHS Consultants Association, so much so that the BMA sponsored an amendment to the NHS (Private Finance) Bill as it was going through Parliament to try and ensure that clinical services would be excluded from any private finance

initiative deal (Healy, 1997, p7). Whilst Ministers have given assurances that clinical services will not form part of any private finance deal, they rejected writing the commitment into law and thus the the BMA sponsored amendment in the House of Lords was defeated (Healy, 1997, p7).

Further changes from 1996

On 1st April 1996 the 8 Regional Health Authorities in England were disbanded (Ham, 1997/98, p17) and in their place, 8 Regional Offices of the NHS Executive were established. The staff in these offices are civil servants, not NHS employees, and each Regional Director is a member of the NHS Executive Board. These regional offices have no strategic financial or planning role. Their role is to monitor the performance of Health Authorities and the activity of trusts (Health Service Journal, 1997, p6).

On the same date, 1st April 1996, the 105 District Health Authorities and the 90 Family Health Services Authorities were abolished and replaced by 100 new unitary health authorities. Their role, amongst other things, is to purchase hospital and community health services for the people who live in their area, to carry out health needs assessments and to manage primary care - through the

contracts with "independent" practitioners (Health Service Journal, 1997, p6) (see Appendix V for post 1996 structure of Health and Social Service provision).

General Election 1997

On 2nd May 1997 a new Labour Government won the General Election with an overwhelming majority. On its very first day in office, the new government announced that the internal market in the NHS would be abolished as soon as practicable. In place of GP fundholding would be installed a system of GP commissioning, details of which were to be announced later. In addition, in mid June 1997, barely six weeks after coming into office, the new Labour Government announced that it was to undertake a "comprehensive review" of the National Health Service.

In a statement at the Institute of Health Service Managers conference in Cardiff in June 1997, the new Secretary of State for Health Mr Frank Dobson announced that "Everything is on the agenda for the review. We have to look at every aspect of health-care. It has to be intellectually honest. We can't pick bits out. We're going to look at priorities for the NHS and how we meet those priorities. There will be no holds barred" (Dobson, 1997, p11). The new government was immediately faced with yet another financial crisis in the NHS, with

more major changes on the way to try and avert, or at least contain, the funding problems looming on the horizon.

This chapter has examined how some of these changes in the organisation and management of the NHS impinge on the role of NHS managers and in particular on doctors in management in secondary care. In the next chapter I shall develop the concepts of power and authority as they relate to the evolving role of doctors in management. The way interest groups influence the organisation and management of the health service is also included.

CHAPTER FOUR
POWER AND AUTHORITY IN THE NHS

The history of the organisation and management of the health service is primarily about medical power and medical dominance and, to a lesser extent, the development of managerial authority. In this chapter I shall examine power and medical dominance since they are at the core of my research theme, the evolving role of NHS doctors in management. I shall discuss how formal authority in the hands of lay managers was very much curtailed by the operation of interest groups, the most influential of which was the professional interest group which, in the main, is dominated by medical staff.

Included in this "problematic" chapter is a discussion of academic debates relating to power and authority in general and in the context of the health service. Questions relating to what is power, what is authority, how has power and its distribution been analysed will be addressed in the chapter together with a

discussion tracing the background of the development of health services organisation and management, including the various influences on the style of management. An attempt is made to assess the difficulties still faced by the NHS, after 50 years in operation, in developing an organisation and management system which achieves its multiple declared aims: the provision of high quality, value for money services, responsiveness to the needs of its patients, and within resource allocations, yet still adhering to its basic principles of equity and access on the basis of need. An examination of these influences will help to explain the present position, as the health service enters a new era, changing from the traditional emphasis on secondary care to primary care with the development and modification of the use of market forces, advances in information technology, a growing emphasis on "evidence based medicine" and an ever more intensive quest to extract better value for money in the services it provides for patients.

Power and authority

Power and authority are much contested and discussed concepts in sociology and social science and numerous definitions abound. Whilst it is not my purpose to thoroughly explore these debates, it is necessary to give brief definitions and analysis of some of these concepts

in order to try to explain the lack of effectiveness most reorganisations have had in the NHS.

Power, in Lukes' view "is not merely about the ability to pursue the options that are "on the table" but also, crucially the ability to control what the options are in the first place" (Lukes, 1974). Dahl (1976, p47) argues that power is exercised when, as a means of influence, the threat of a sanction is made, whilst Etzioni considers that power can be exercised through coercion, reward or persuasion (Etzioni, 1975). In the opinion of Pfeffer and Salancik, the logical corollary of power is dependence; the two are inversely related (Pfeffer and Salancik, 1978, p51-52).

Authority involves, "legitimacy" (Bachrach and Baratz, 1970, p32). Mintzberg states that, "Formal authority vests the manager with great potential power" (Mintzberg, 1989, p16). In the understanding and classifying of ways in which power is distributed within a society or an organisation Weber's work has been influential. (Weber, 1947). Weber defines authority as legitimate power with the basis for legitimation based on three distinctive forms:

- i) Charismatic leadership/authority
- ii) Traditional authority
- iii) Rational-legal authority

Legitimate authority on charismatic grounds relates to extraordinary qualities by the individual exercising domination, which constitute the basis of his/her leadership. On traditional grounds the claim to authority is derived from customs and practices of a particular social group as they pass through generations, whilst rational-legal authority was seen by Weber as the distinguishing vehicle of legitimate power in the organisations of industrial society. Weber described this as bureaucracy which is the organisational arrangement through which rational-legal authority is institutionalised. (Weber, 1947). He contends that the claim to legitimate authority on rational-legal grounds rests "on a belief in the legality of patterns of normative rules and the right of those elevated to authority under such rules to issue commands" (Weber, 1947, p328).

Bureaucracy manifests itself in highly developed and formalised divisions of labour, extensive hierarchies of command, rules and procedures. Another conceptualisation of power lies in the professional model in which specialised knowledge and autonomy emerge as critical defining qualities. Weber saw professionalisation as a manifestation of the "rationality" which drives bureaucracy, but often seen as in conflict (Weber, 1947).

In the NHS both of these conceptualisations of power are evident within its organisational structure, in that its bureaucratic organisation also includes a very powerful professional group, doctors. The emphasis in the bureaucratic model on the use of rules and protocols, one objective of which is to produce standardisation, can lead to a ritualism which may often clash with the knowledge and autonomy style of the professional model. Examples of this can be seen in the health care situation with the development of protocols and procedures designed to ensure uniformity and reduce the perceived idiosyncracies associated with "clinical judgement" but which can have the effect of reducing professional autonomy and innovation.

Many researchers have identified the contrast between the formalism of Weber's model and the informal features in organisations which in practice sustain them. In particular, rule use i.e. ritualism, or the habitual use of a rule even when no longer appropriate; retreatism or the use of rules to protect or defend oneself; and reductionism, the perverse way rules can reduce as well as enhance standards of behaviour, are informal features which are not prescribed by the organisation, but arise as a way of handling the inherent contradictions of different

bureaucratic characteristics (Gray and Jenkins, 1999, p197).

Ham, in analysing the distribution of power in health care systems i.e. who controls the services and who influences the allocation of resources, considers a number of theoretical approaches (Ham, 1992a, p220). For Ham, pluralist theories offer a convincing explanation with their analysis of a large number of different groups competing for resources and most decisions emanating from bargaining between these groups (Ham, 1992a, p233). In contrast, Marxist theories of power challenge the assumptions behind pluralism and argue that health services are dominated by the bourgeoisie whose interests are served by prevailing concepts of health and illness. A Marxist perspective would consider that health services help to legitimate capitalism and to promote capital accumulation. For Marxists, pluralist theories concentrate on surface struggles while neglecting deeper class conflicts (Ham, 1992a, p234). In contrast to pluralist and Marxist approaches, Ham considers that Alford's theory of structural interests (to be discussed later in this chapter) looks beyond the surface politics of pressure group conflicts and finds not class struggle, but professional dominance (Ham, 1992a, p234).

Another conceptualisation of power can be seen in the writings of Foucault. He considers that the analysis by Bentham of the system of surveillance makes Bentham "one of the most exemplary inventors of technologies of power" (Foucault, 1980, p156). Foucault points out that surveillance is a form of power in which there is no need for arms, physical violence, or material constraints. Each individual is encouraged to exercise surveillance over and against him/herself. "A superb formula: power exercised continuously and for what turns out to be minimal cost" (Foucault, 1980, p155). The relevance of Bentham's thought in modern day conceptualisations of power is in the general importance it assigns to the techniques of power (Foucault, 1980, p160). For example in terms of management control in the health service, the phrase "electronic panopticon" (Bloomfield, Coombs and Owen, 1994, p138) represents a fusion of the surveillance potential of rapidly developing information technology with Foucault's discussion of prison architecture and Bentham's model prison where prisoners could be observed from a central tower, but could not be sure themselves as to whether or not they were being observed (Foucault, 1980). Whilst traditional models conceptualise power as being primarily repressive, Foucault considers it primarily productive in that power is bent on "generating forces, making them grow, and

ordering them, rather than "dedicated to impeding them, making them submit, or destroying them" (Foucault, 1980). For Foucault, power is diffuse, operating from the bottom up rather than from top to bottom (Annandale, 1998, p37).

Postmodern perspectives can also contribute to the debate on power and authority in health services with their rejection of the "grand narrative" of a single rationality. For example Kelly, Davies and Charlton, in an article concerning the Healthy Cities movement state that the core idea of post-modernity is that the social and moral conditions pertaining in the world at the present time mark a fundamental break with the past. In art, form displaces content; in philosophy, interpretation displaces system; in politics, pragmatism displaces principle; and in science chaos displaces order. To be paradoxical, "The core idea of post-modernity is that there are no core ideas!" (Kelly, Davies, Charlton, 1993, p159).

An example of these postmodern perspectives can be found in the writings of Fox (Fox, 1991: 1993). Fox, from a postmodern perspective sees "all organisations as mythologies constituted discursively to serve particular interests of power and contested by other interests of power" (Fox, 1993, p49). He sees organisation as

process rather than structure, reactive or remedial, existing only in relation to disorganisation. In any attempt to evaluate health care services, a postmodernist perspective rejects the idea of a single rationality. In the opinion of Fox, rationality is a "fragmentary phenomenon, conjured by local processes concerned with power and exclusion" (Fox, 1991, p722).

In an analysis of power relations in a clinical setting, Fox demonstrates how any concept of "outcome evaluation" in healthcare is impossible without considering the criteria for outcome success and that these are not technically nor rationally self-evident. The crucial point for postmodernism is that the criteria are unlikely to be the overt ones, nor to be the same for different groups (Fox, 1991). Postmodernism addresses "knowledge" from the standpoint that it is constituted by power and by interests. In postmodernism the investigation of knowledge (and therefore of power) lies in the methodology of deconstruction, (a strategy to explore the authority by which a statement or claim to truth or knowledge has been made) (Fox, 1993, p161) which attempts to reveal internal contradictions within discourses and the processes of negotiation between them. In health care evaluation for example, deconstruction would help to identify local practices, which prevent

achievement of particular objectives, but which enhance the alternative objectives of specific groups and individuals such as the maintenance of hierarchies (Fox, 1991, p724). In terms of the themes of this thesis, postmodernist perspectives can thus be helpful in contributing to an understanding of the struggles and negotiations between different "discourses" in the health services and of the likelihood of an increasing challenge to the medical discourse (and thus medical power) as faith in "grand narratives" declines.

In considering competing discourses and in particular those relating to clinical versus managerial rationales, one of the discourses which NHS managers may draw upon is health economics. This is often portrayed as rational, technical and as a matter of producing "facts", but as Mulkay, Ashmore and Pinch (1987) discuss in an article "Measuring the quality of life", can more plausibly be seen as one of a number of competing discourses. (Mulkay et al, 1987, p541-564). These authors argue that the claims of specific groups of "knowledge producers" (in this case health economists) are often depicted as "the preferences of the population at large" or the "real world" of everyday action when in fact such knowledge is socially generated and is only one way of looking at the world (Mulkay et al, 1987 p550-560). They question the

background assumptions by health economists that there is some quantifiable phenomenon, previously inaccessible to administrators, called "evaluation of quality of life" which enables them (the economists) to make a distinctive contribution to the administrative process (Mulkey et al, 1987, p559) when in fact it is an interpretative by-product of, amongst others, health economists themselves. In the opinion of Fox, the economic model assumes a rational economic actor who always selects the most efficient means (through the acquisition of commodities or services) in order to attain his/her objectives (Fox, 1993, p127). So, for example the health economists' Quality Adjusted Life Year (QALY) is regarded as a tool to assess the relative cost-effectiveness of different medical technologies upon patients' extent and quality of survival (Fox, 1993, p127) and as such a formal rationality (the estimation of a QALY score). However the application of this rationality does not insulate the procedures from the vested interests of economic discourses or those in a position to influence economists' judgments (Fox, 1993, p127) using different data sets to the epidemiologically orientated information used by clinicians (Salter, 1998, p34).

In contrast to the economic rationale, the clinical rationale presents a competing discourse which focuses

primarily on individual patients including those whose medical condition would never warrant consideration if judged purely on a population wide cost-benefit analysis basis. Richards and Lockett argue that to seek the greatest good for the greatest number (the health economist approach) may result in decisions whereby small numbers of individuals who are in greater medical need may lose out whilst the majority have their relatively trivial needs met (Richards and Lockett, 1996, p24). There are therefore dangers if a health economics approach challenges the medical model as an alternative "grand narrative." Whilst the health economics approach may seem attractive to managers in providing a technical solution to their problems associated with resource allocation, there is thus, as Ham points out, continuing controversy of the usefulness of tools such as "Quality Adjusted Life Years" (Ham, 1991, p75).

Professional power

Health service managers and doctors both have "authority" - i.e. legitimate power, but for managers this derives from their position in a bureaucratic structure, where for doctors this derives from professional status. Flynn, writing about professional power, states that in this case, power (defined as "the capacity to influence the action, beliefs or values of others") can be effected

through the possession of scarce expertise and skills (Flynn, 1992, p24). One could distinguish between formal and informal mechanisms for exercising power. Both managers and doctors have formal and legitimate power and both may also seek to exercise this power in informal ways, but doctors seem to have been particularly successful in this.

In the health service, consideration needs to be given to the extent of power of consultant medical staff which has prevented the exercise of the legitimate power and authority of managers over them. Particularly following implementation of the Griffiths Report 1983 (Department of Health and Social Security, 1983), the rhetoric was that general managers and chief executives would have considerable levels of authority over all grades of staff. The reality however, was that this did not extend to consultant medical staff. In the opinion of Harrison, "The prime determinant of the pattern of the health services is still, just as before Griffiths, what doctors choose to do" (Harrison, 1988, p123). Since consultants are the organisation's largest spenders and commit considerable resources this is extremely important and is at the core of my argument relating to power and authority and the evolving role of doctors in management. Indeed, prior to the involvement of doctors in management,

it was possible to argue that the very direction of the health service was determined by an aggregation of the decisions of individual, powerful, consultant medical staff and had little to do with the formal power and authority of lay management at all! (see chapter 6).

Alford's Structural Interest Theory/Domain Theory

One analysis, favoured by Ham as a way of explaining the influences which have been at the heart of health service organisation and management (Ham, 1985, pp195-6), is afforded by Alford who developed his "Structural Interest Theory" following a study of the New York health care system in the 1970s (Alford, 1975, p155). It has been modified and updated over the years and is now more commonly referred to as "Domain Theory."

Alford argued that sectional vested interests in the health care systems in New York had the effect of suppressing the interests of, in his terms, "The Community" (Alford 1975, p199). Following his own case studies of health care in New York City between the 1950s and 1970s, which included empirical data derived from interviews, documents and secondary sources, Alford came to the conclusion that the interplay of three sets of structural interests currently stultified change. He called them: professional monopolists, who are the

dominant interest; corporate rationalizers, who are the challenging interests; and the community population, who are the repressed interests (Alford, 1975, p14). The first two sets of interests, Alford considered, hindered changes being made which would have been of advantage to the third (Alford, 1975, p14).

In applying the theory one needs to examine what the forces are which hinder changes being made, changes which could be to the advantage of patients and prospective patients of the National Health Service. Domain Theory (which is a development of structural interest theory) is put forward as a means of explaining these forces.

Following the Griffiths inspired introduction of general management into the NHS, Edmonstone developed Domain Theory in the British context and described the three domains, as Professional; Political; and Management (Edmondstone, 1986, pp8-12), with the patient/consumer (or in Alford's terms "The Community") as a constituent of the political domain (Mark and Scott, 1991, p199). In effect Edmonstone adapted the theory to reflect the important role of national government in health services in this country.

Edmonstone sees the Professional domain as denoting professional autonomy, with self governing experts who are perceived to have the competence to respond to the needs and demands of patients. The Political domain is seen as Parliamentary, i.e. representative democracy, with an emphasis on the consent of the governed. The Management Domain attempts to mirror the image of industrial management, with an emphasis on a comprehensive, rational view of the world and on hierarchical control and co-ordination (Edmonstone, 1986, pp8-12). I shall examine all three domains to try and assess how far they can explain the on going dilemmas of the NHS.

The Professional Domain

The Professional Domain ranks in accounts of Domain Theory as the most powerful. Doctors, and to a lesser extent, other health care professionals, have a one-to-one relationship with patients, claim to act in the best interests of the sick and to possess the necessary expertise to be able to do so. This allows a high degree of autonomous action which is unchallenged, indeed in the clinical sphere, very often unchallengeable. As stated by Williamson, "The wide acceptance of this ideology is a major cultural support for dominant interests." (Williamson, 1988, p171), and is linked to the acceptance of the

medical model as the appropriate basis for a healthcare system.

Power can be exercised in the NHS, especially by medical consultants, through the possession of scarce expertise and skills (usually a monopoly of knowledge and resources for treatment) which makes others dependent on them. Central to this power position is argued by many to lie in the dominance of the medical model of health (Turner, 1987, pp157-158). While health was seen as produced by medicine, doctors (and to a lesser extent other professionals working within the medical model) would be seen as the experts within the National Health Service.

Of particular relevance to the power position of medical consultants are the important aspects of clinical autonomy/clinical freedom, the notion that a fully qualified doctor cannot be directed in his or her clinical work (Harrison et al 1992, p24). Freidson considers that medical power derives from this autonomy with the interrelated dimensions of dominance and the professional status of doctors. He considers that autonomy is the power of doctors to control their own work whilst dominance gives them the power to control the work of others in the health care system. Taken together they

afford the profession a type of isolation and an "opportunity to develop a protected insularity without peer among occupations lacking the same privileges" (Freidson, 1988, p369). Hunter also refers to the professional status of doctors when he contends that the power of the medical profession is not only related to clinical autonomy and dominance, but significantly to the high social standing the profession still enjoys (Hunter, 1994, p19).

However clinical autonomy is both a political and a professional issue. Senior Consultant Medical Staff have always been influential in how the organisation of the NHS works. Through their professional representative machinery and their professional boards and committees, they have formed a very powerful political lobby at both national and local level. Meanwhile, at an individual professional level they also have jealously guarded their freedom to take clinical decisions without interference from others, be they politicians, chief executives or general managers or even, at least until recently, other doctors. When to this is added the control of medical staff over a substantial proportion of expenditure in the NHS, it would seem reasonable to conclude that management has not controlled the NHS; professionals, in particular medical professionals, with political power and

professional legitimacy have. As asserted by Smith, "Clinical Autonomy therefore presumes unmanaged status for medical staff" (Smith, 1984, p4). However as Williamson suggests, "In Alford's theory, interests are not tied exactly to the interest groups. Other people in the health service and outside it, accept, by and large, the autonomous health care professionals' interest and power" (Williamson, 1988, p170). It follows therefore that those professionals, even with their vested interests, are supported without ever having to make a great issue of promoting their interests, because it happens virtually automatically, since most of the time, other institutions and people within and outside the service, do it for them (Williamson, 1988, p170). This again illustrates the acceptance of the medical model.

This "structural support", makes it enormously difficult to bring about changes at variance with the interests of this professional group, even in circumstances where changes could well be to the advantage of consumers, (indeed until the reforms which followed the White Paper, "Working for Patients" in 1989, it seemed quite impossible). For those outside this dominant interest group, it takes considerable effort and great skill to have their voices heard, primarily because of their low structural support.

Doctors have power at an individual level as well as at a corporate level. On an individual basis, the medical model of care as the "meta-narrative" of health care systems is at the core of their power from which is derived their professional status, their autonomy and dominance and their high economic and social status. Gender is also likely to be of significance: doctors are members of a profession which is historically male, compared with other health professions which are predominantly female. On a corporate level they have a sophisticated influence and lobbying system through their membership of, for example, the British Medical Association and appropriate Royal Colleges and prestigious national committees. In terms of power politics, a good example of the control exercised by the medical profession is in the responsibilities of the General Medical Council, a body which sets regulations for the registration of medical staff and for the educational approval of medical training posts in hospitals. This is a very powerful position for the General Medical Council to have in terms of power politics. Such a position allows it to influence decisions on several issues, including case mix, numbers of beds, numbers of medical staff, numbers and qualifications of support staff, duty rosters, consultant supervisory cover, post graduate education and training, study leave, availability of technical equipment, hospital

facilities, premises etc etc. The manager, faced with this sort of pressure is forced to ensure that adequate resources are in place in order that educational approval be granted.

In Alford's view, health care professionals who hold a monopoly for the provision of their services which is upheld by the state are "professional monopolisers", who are, in the main, doctors (Alford, 1975, pp14-15). This domain sees management at worst as "an interference", or at best as a service for them - providing the environment in which they can freely practice their profession.

The Political Domain

The political domain can be looked at in several different ways. For example, at the macro level the NHS is a public service, financed almost entirely out of public monies, the largest part of which is general taxation with the remainder coming from indirect taxation in the form of National Insurance contributions and a small amount from charges.

Funding the NHS is a major political issue. The Minister responsible for the NHS, The Secretary of State for Health, has to compete for funds with all the other spending departments in central government and he/she is

responsible to Parliament for the discharge of those funds. As stated by Smith, "The policy (political) domain relies on bargaining and voting to make decisions and values debate and acceptable disagreement. They (the politicians) are elected representatives whose legitimacy derives from the consent of the governed. Success in this domain is measured by the quantity and especially the quality of decision making" (Smith, 1984, p6). So great is the expenditure on the NHS (something in the order of £29 billion pounds in 1990 (Ham, 1991, p44), rising to over £40 billion in 1995/96 (Appleby, 1997, p32), and to some £42 billion in 1997 (Maynard, 1997), that considerable political pressures abound to justify this level of expenditure.

In addition to finance, the NHS is highly regarded by the vast majority of the British public and has a special place in British life. It has "The consent of the governed", as Smith puts it (Smith, 1984, p6). The NHS frequently tops the political agenda, especially at times of general elections. For example, in the run up to the 1992 general election, politicians of all persuasions were quick to point out that the NHS was either "safe in our hands" or that "increasing funds would be made available" to maintain and improve services. Similarly, in the recent general election of 1997, which returned a Labour

Government to power, health issues played a major part in the election campaign, with the Labour party promising to "re-nationalise" the health service and a "real rise in funding year on year for the lifetime of this parliament" (Appleby, 1997, p32). Regardless of which political party is trying to win electoral votes, there is always a political awareness that one of the major issues which can win or lose an election or indeed place a government at risk of being removed from office, is the National Health Service. Even in 1952 it was Bevan who said that, "No government that attempts to destroy the health service can hope to command the support of the British people" (Bevan, 1952). Davies, writing in 1998, states, "That has remained an unbending law of British politics as applicable to Thatcher, Major, Blair as it was to Attlee, Churchill, Macmillan (Davies, 1998, p1). It is therefore essential for the government of the day to involve itself heavily in the National Health Service in order to protect itself politically and also to convince the general public that the enormous cost of running the NHS is producing good quality services, in line with the basic principles of the NHS of equity and equal access. Immediately this creates conflict between these national level politics and the politics of those at the operational level. Whilst central government plays lip service to giving more freedom of decision to those at the operational level in

order to avoid the criticisms of remote decision taking (and in order to distance itself from things that go wrong!), the politics of the NHS demand that the government of the day must still be seen to be in charge of the fortunes of the NHS, even though the politics of the centre are vastly different from the politics at operational level.

It is at the operational level where politics intertwine more with professional interests, where clinical autonomy, status, career structures, job security, grades and salary levels are more important considerations in the relationship with the medical profession than national policy decisions which are often linked more to political considerations than to achieving better organisational systems. Such national political decisions are inevitably often at variance with the politics at the operational level and immediately result in conflicts of interests. An example of this is the (successful) resistance of medical staff to locally negotiated pay.

One of the criticisms of the idea of the political domain is the suggestion that within this domain there is some neat uniformity which, although at variance with the other domains, maintains an ordered stance within itself.

This is not the case. The political domain now includes for example the role of Health Authorities and Trust Boards (and from April 1998 the Primary Care Groups) adding a new dimension to the political (and management) domains. These bodies have a two fold role i.e. political and managerial. Indeed, questions could be posed, are there heterogeneous overlapping and conflicting groups within the domains? Are the three domains becoming more overlapping underlining the fact that the NHS is a vastly complex organisation at all levels, seeking to find an organisational system which will accommodate all, or even some, of the competing interests. In Smith's words, "The NHS is both multiprofessional and multi-structured; the various occupational hierarchies being incongruent. This arrangement is further complicated by autonomous groups of staff, huge spans of control and other factors" (Smith, 1984, p4). Also the inclusion of patients/consumers/the "community" in this domain makes the assumption of homogeneity and common interests within the domain even more suspect.

The Management Domain

The Management Domain would appear to be the most vulnerable and least valued of the three domains over most of the history of the NHS. It is frequently used by politicians and indeed by professionals as a scapegoat for

things that either go wrong or initiatives that do not develop in the way politicians and/or professionals envisaged. Managers have been relatively powerless and hence subordinate to the other domains (Smith, 1984). Examples of this scapegoating can be cited such as the "waiting list" issue which attempted to link waiting lists to managers' performance-related pay and the reinterpretation by the government of the 1987 crisis in the NHS as a result of "poor management." Further examples can be found in the present Labour Government's statements relating to improving value for money by releasing more funds for patients through "cutting wasteful bureaucracy", with a proposed £100 million cut in management costs in 1997 (Crail, 1997, p11). There is considerable pressure on management to ensure quality, value for money services and to use complex systems and new technology to make improvements, very often without extra resources to do so. Those in the management domain have to focus on organisation-wide efficiency as opposed to the individual face-to-face approach of the clinical professional. The manager seeks to make better use of resources like staff and money (Williamson, 1988, p171) and his/her success is measured in large part against these requirements. An example of this is the requirement, from the mid 1980s, to produce year-on-year

"cost improvements" through "efficiency savings" which do not reduce the level of services provided.

Alford called managers "Corporate Rationalisers" (Alford, 1975, pp14-17). In the words of Williamson, "Corporate rationalisers try to control the conditions of work of doctors and their use of resources" (Williamson, 1988, p172). This raises the question of whether the most effective managerial challenge to the professional domain will be when the manager is also a doctor? To give the manager, who is also a doctor, responsibility for budgetary control across an organisation wide structure is asking him/her to challenge the professional domain's spending habits by trying to move away from the focus on individual face to face interactions and decisions and to reconcile resource allocation with levels of patient care over a wider spectrum.

Some doctor managers, especially with the advent of Medical and Clinical Directorate systems (to be discussed later, see chapter 6) have undertaken to do this. Some doctors have preferred to remain solely clinicians, others after a brief period as managers have retreated from their experience of the management domain to the relative security of their former professional domain, an option not open to non clinical managers.

One way of interpreting the reforms following the 1989 "Working for Patients" White Paper is in terms of a shift in the balance of power between and within the three domains. For example the government sought to increase the power of patients as consumers. It therefore directed the Management domain, with its waiting list imperatives and the Patients Charter, and the Professional domain with its directions to GPs following the White Paper, "Promoting Better Health" (Department of Health and Social Security, 1987), to become more responsive to consumers needs (Mark and Scott, 1991, p199). The rhetoric by government was to increase consumer power. One suspects however that the reality was the aim to change the balance of power from the professional to the management domains or maybe using managers as vehicles for an increase in power of the political domain. Hence the introduction, for example, of compulsory medical audit (see chapter 3, pp99-100).

The strengths of the theory stem from the acceptance of the reality of politics in organisational life; it explodes the myth of rationality by questioning whose goals are being served (Mark and Scott, 1991, p193). The theory highlights human behaviour and the interplay of structural interests. However, according to some this has positive rather than negative outcomes. For example,

Kouzes and Mico argue that "They (the domains, which could be described as interest groups) act together as an organisational check and balance system and in so doing they meet the multiple needs of human communities" (Kouzes and Mico, 1979). These views by Kouzes and Mico are very different from Alford's assertion that the needs of the "community" are not met because of the influence of other, dominant interest groups.

However, Smith shares Alford's pessimism. For him the weakness of the healthcare system, if one accepts domain theory, is that it incorporates three systems which have, "different values, structures, methods of internal control and success measures" (Smith, 1984, p6). Each domain has its own separate identity, with each domain having values quite different from either of the other two. The domains do not exist in harmony, they do not have the same goals and objectives, communications with each other are poor, therefore they are often in conflict, one domain taking a course of action which not only suppresses the other, but which in many instances, alienates and weakens relationships between powerful interest groups throughout the domains. The domains tend to look at one another, but do not look outside the domains at external pressures (Smith, 1984, p6). Ham sees a close link between Alford's analysis of the U.S situation and the U.K. He argues

for the relevance of structural interest theory to the NHS (Ham, 1985, pp195-6). Smith, supports this stating, "It allows us to contrast the approaches of the various systems" (Smith, 1984, p6). In the opinion of Mark and Scott, "Domain Theory offers a persuasive explanation for much of the discord and uneven development of ideas and actions in the NHS" (Mark and Scott, 1991, p194).

A related explanation of why the NHS is still trying, after 50 years, to develop an effective and efficient organisation and management system is put forward by Marnoch. He contends that from the outset there has been a flaw in the development of the NHS which the major reorganisations have failed to resolve which is the failure to connect policy and structural reform to the world of the medical profession (Marnoch, 1996, p12). The reorganisation of 1974, The Griffiths Report of 1983, and The NHS and Community Care Act 1990 all failed to address the old problem of a lack of articulation between strategic, locality and management in the NHS (Marnoch, 1996, p20). In Marnoch's view, "The medical profession remained adrift of control from the higher levels in the NHS organisation" (Marnoch, 1996, p20). Marnoch's views fit in with domain theory so far as medical staff are concerned. The dominance of medical staff in the

professional domain allows them to remain immune from managerial control.

Challenges to medical power

There are however challenges to medical power and to the medical model from a number of areas. Examples of these challenges can be seen in increased government pressure on resources, such as cash limits and year on year efficiency savings (without any diminution of services). In the clinical directorates (see chapter six), the definitive budgets for which Medical/Clinical Directors are personally responsible, are constraints on the spending habits of individual consultants thus limiting their power to commit resources which may be at variance with the agreed business plan for the Directorate and/or Trust. From the early 1990s, the main incentives for Trusts were now business incentives and emphasis was placed on the need to generate income (Appleby, 1992, p136). These considerations mitigated against individual consultant's freedom in resource use.

In addition scepticism grew about the effectiveness of medicine. This derived from critiques such as those of Illich (1976) and McKeown (1976, pxiv) questioning the contribution which medicine has made to improvements in health and emphasising the damage to health which some

medical interventions cause. Challenges to the status and expertise of doctors also came from the rise in consumer/user power (Salter, 1999, p155).

Other examples question the "taken for granted" notion that clinical expertise is of the essence. For example, government initiatives such as the Health of the Nation and Our Healthier Nation (which were discussed in chapter three), promoting public health and encouraging citizens to look after their own health emphasise the importance of lifestyles and choices rather than medical interventions and in effect encourage individuals to exercise surveillance over themselves (as Foucault describes) (see pp140-141) rather than see this as the responsibility of doctors. Not only does this suggest a shift from the view that it is medicine which produces health, but, if it does result in a healthier, more self-sufficient population, it could reverse the trend towards the "medicalisation" of more and more aspects of individuals' lives which has been so condemned by critics such as Illich (Illich, 1976).

As discussed earlier (see pp 141-143) postmodernism is one way of understanding these challenges to medical power. A central argument of postmodernism is that the tendency in the "modern" era to have dominant discourses

or "meta-narratives" such as the medical model, has been replaced in the "post-modern" era by a multitude of competing discourses and a loss of faith in "meta-narratives."

One example (see pp143-145) of the emergence of a competing discourse is the incorporation of the language and techniques of health economics into managerial discourses (Mulkey et al, 1987). The rising status of health economics, perceived as having an important contribution to make to decisions about resource allocation in health services, has implications for the power and status of doctors and medical knowledge and practice and the relationship between doctors and managers. Health economists aim to shift the purchasing agenda away from a focus on "needs" to "marginal met need for resources expended" (outcome, costs and benefit) (Salter, 1998, p34) in order to identify those interventions which contribute most to reducing need per pound spent (Donaldson and Farrar, 1991) whilst the medical discourse keeps sight of the one to one patient relationship and the medical needs of smaller numbers of individual patients. Not only can these differences help us to understand the likely difficulties in the relationship between doctors and managers but they are also likely to create dilemmas for those doctors who are

also managers; not only at an individual level, but also in terms of their status, power and influence in relation to their medical peers and their patients.

In comparison, other examples of the challenges to the power position of medical consultants relate to some of the changes which have taken place and which have prompted commentators to refer to the "proletarianisation" and the "deprofessionalism" of the medical profession (Annandale, 1998, p225). Proletarianisation is "the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism" (McKinlay and Stoeckle, 1988, p200).

Annandale argues that this process seems unlikely to occur to any extent among doctors due to the clinical expertise consultants have in a state-sponsored monopoly. This clinical expertise is the basis of professional power. (Annandale, 1998, p228). Hunter agrees, contending that the proletarianisation of the medical profession as a result of the management reforms is far from complete and that doctors retain considerable influence over resource use and health policy (Hunter, 1994, p19).

Deprofessionalism, "a loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos and expectations of work autonomy and authority over clients" (Haug, 1973, p197) may be more of a threat it is argued, as more and more knowledge is available to the public and with consumerism having an impact on doctors' work. However, in the opinion of Elston, this does not seem to constitute a significant challenge to professional dominance overall (Elston, 1991). What is happening to the medical profession, according to Freidson, is that divisions within medicine are intensifying. As Annandale describes, "the medical profession is dividing and policing itself in order to keep external control at bay" (Annandale, 1998, pp222-223). This is apparent in the way the collective power of doctors is enhanced by moving into management positions and even though this might well undermine the freedom of individual doctors, or other segments of the medical profession, it may be the price they are prepared to pay to avoid non medical control. It could be argued that the involvement of doctors in management is a subtle way of control by "incorporation" rather than by "direct" attack (Annandale, 1998, p238). Is this co-optation of doctors by government in order to sell rationing of services and cost-cutting measures, or is it a shrewd move by doctors to take control themselves?

In support of the latter view, in the opinion of Harrison and Hunter, when doctors are involved in management their decisions are based on "what is best for physicians" (Harrison et al., 1992; Hunter, 1994). By the mid-1990s Hunter considered that "suggestions that medicine is under siege by numerous forces arranged against it in the shape of assertive managers and policy makers are almost certainly premature" (Hunter, 1994, p17).

There is also a challenge to the clinical autonomy which consultants have maintained for so long. So widespread and revolutionary were the organisational changes of the 1990s in the "new" National Health Service, coinciding as they did with great advances in medical technology, new treatment regimes, new drugs, information technology etc, that a new approach to making clinical decisions is emerging. A crucial shift is the shift from the individual doctor's clinical autonomy, to guidelines (produced by groups of doctors) to which individual doctors must adhere. In addition, evidence based medicine, which was discussed in chapter three, has the potential, on the one hand to change the traditional nature of clinical considerations influencing decisions in favour of "scientific" cost and other considerations. On the other hand however, evidence based medicine could also be a means for doctors to produce "evidence" with which to

demand more financial resources in order to follow treatment regimes in accordance with the "evidence", thus adding power to the medical position.

Stacey however warns against the view that the autonomy of medicine should be dismantled. She argues that many effective voices of opposition have been tamed by government and that, despite its self interest, the medical profession has on occasions been the patients' advocate and an effective public ally (Stacey, 1992). Freidson also argues against attacks on clinical autonomy, claiming that standardisation reduces the ability of medical staff to respond to individual patient need (Freidson, 1994).

A more recent challenge is in the politics of self regulation. In an article on change in the governance of medicine, Salter shows how the political forces at work in the triangular relationship between medicine, society and the State interact to guide and constrain change in medicine's system of governance (Salter, 1999, p143). The highly politicised nature of self regulation (accentuated by the Bristol tragedy) (see pp 64-65) has however created the public's "newly awakened awareness that it can no longer trust the medical profession to deliver healthcare of an appropriate quality" (Salter,

1999, p155). In the opinion of Salter, the medical profession, under pressure from society and the State, will now be obliged to reform itself with regard to its self regulation and accept a higher degree of public accountability (Salter, 1999, p143).

As already discussed in this chapter, medical power, indeed the medical model itself, was being challenged in the mid to late 1980s and continues to be challenged in the 1990s, evidenced for example by the increasingly active management of workloads, output and costs which weaken the exclusivity and monopoly traditionally claimed by doctors (Flynn, 1992, p39).

However the history of the NHS is one of doctors having a disproportionate influence over the structure and organisation of the service and of the use of resources (Flynn, 1992, p25), and it would be unwise to underestimate the remarkable ability of the medical profession to adapt to changing circumstances in order to protect its professional interests.

One of the ways in which doctors have begun to adapt is by moving increasingly into the management domain. What are the implications of this merger of professional power and bureaucratic authority? Does this provide a

more effective way of "articulating the relationship between action and structure" (Ham, 1985, p206). Could the more active formal involvement of hospital medical staff in management, with accompanying accountability and responsibility, be a way of harnessing the professional authority of the consultant with the authority to manage, thus achieving a blend of these two sources of power? What might be the implications of this for individual doctors, the medical profession as a whole, for non clinician managers, and for other groups of NHS workers, as well as for patients and the type of care they receive?

Earlier in this "problematic" chapter, the wider academic debates in the areas of power and authority were discussed. On the basis of these discussions a number of questions emerge, such as:-

- * How far is it increasingly evident that alternative discourses, such as those which Fox and others have identified in the context of a post-modernist perspective, are challenging the meta-narrative of the medical model? Does this mean for example that managers with their alternative source of authority deriving from their management, financial and health economics discourses which seem increasingly in

accordance with government policy, pose a more effective challenge to consultant power? How far is this more likely if these managers are also doctors? (see p387).

- * Alternatively, is the medical model with its accompanying clinical autonomy still a major source of power for consultant medical staff? (see p391).

- * Will doctors who have become managers operate in ways which consolidate or challenge the historically powerful position of their profession? (see pp391-392).

- * Have there been changes in the balance of power in the NHS between doctors, managers, politicians and the public? (see pp387-388). Is there a shift of power occurring from individual doctors to the collectivity of doctors brought about by, for example, clinical audit, the appointment of medical and clinical directors and the rise of evidence based medicine? (see p390).

- * Has the emerging "maturity of citizens" enabled the hidden domain of "the community" to challenge the "taken for granted" notion that clinical expertise

is the only real source of power in the health service? (see p388).

- * How far do the changes which have occurred challenge the "domain theory" analysis of power in health services put forward by Alford and others? Does this encourage a fresh look at Domain Theory e.g. the increasing overlap between domains, increasing divisions within the domains, emergence of community (consumer) interests, shifts in the balance of power between domains? (see pp388-389) What are the implications of a shift from the medical model of care? (see p388).

These and other questions will be addressed in the fieldwork chapters (chapters 7-9) and in the light of the fieldwork, returned to in the thesis conclusion.

The discussion in this chapter has mainly focused on secondary care. In the next chapter, the radical policy changes which were being made in primary care services will be discussed and the impact they had on doctors in management.

CHAPTER FIVE
DOCTORS IN MANAGEMENT IN PRIMARY CARE

Whilst the main focus of my research centres around doctors in management in secondary care health services, it is also extremely important to recognise the role of doctors in management in the primary care services.

In the previous chapters we have seen the enormous changes which are occurring in secondary care. The changes which are happening in primary care, have been, if anything, even greater. At the same time as revolutionary advances were being made in the medical treatment of patients, with new drugs, new treatment regimes etc, the changes in the organisation and management of practices were fundamentally changing the way general medical practice operates and will operate in the future.

The objective in this chapter is to show how these changes are impacting on the role of doctors in

management in general practice. It is therefore the area of general medical practice which this chapter will explore.

Background

The most powerful and most influential professionals in primary health care are the General Medical Practitioners. The services they provide resulted in over 225 million consultations each year in the mid-1980s (Secretaries of State, 1986). Described by the then Secretary of State Stephen Dorrell, as, "The jewel in the crown of the Health Service", this was a clear recognition by the Government of the importance of General Medical Practice (Dorrell, 1995).

Primary health care services, i.e. those services provided by family doctors, dentists, community pharmacists, opticians, and community nurses, are regarded as "The front line of the National Health Service" (Department of Health and others, 1987, p59). These services account for some 20% of all NHS expenditure (Appleby, 1997/98, p62). This expenditure, which in 1987, was about £500 million per year (Department of Health and others, 1987, p7), had increased to some £8.8 billion by 1997/98 (Appleby, 1997/98, p62), with over 90% of all episodes of illness managed wholly in general

practice (Jarrold, 1997/98, p74).

In the mid 1990s, General Medical Practitioners received about 60% of their income from capitation payments, the remainder coming from fees and target payments for services they provide, such as vaccination and health promotion clinics (Appleby, 1997/98, p62). Those who were fundholders also received an allocation from the local health authority (from 1996) for budgets designed to enable them to buy selected secondary and other services (Appleby, 1997/98, p62).

In 1994 the number of unrestricted GP principals in the UK was 32,751. In England and Wales in 1993 there were nearly 10,000 partnerships (counting single-handed GPs as partnerships of one). The average list size of unrestricted principals in England and Wales at 1st April 1995 was 1,872 patients whereas in October 1985 27,889 unrestricted principals had an average list size of 2,059 (Jarrold, 1997/98, p74).

The traditional image of the single handed general medical practitioner managing his/her own medical practice has long since gone, with the advent of group practices and partnerships. For example, by 1995 the trend towards larger practices and partnerships which had been

accelerating in recent years, had resulted in the following percentage distribution of unrestricted GPs by type of practice in England:-

	%
Single handed	10
In partnership	
Two doctors	14
Three doctors	15
Four doctors	18
Five doctors	16
Six or more doctors	27

(Jarrold, 1997/98, p74).

There had also been an increase in the range of activities in which general medical practitioners were required to participate, following the introduction of the GP contract in 1990, together with a substantial expansion in the number of professional staff employed by, and in general practice. The number of practice staff (whole time equivalents) has more than doubled in the last ten years, with almost six times the number of practice nurses in 1993 as in 1983. In April 1995, 10,410 GPs in England were in 2,603 fundholding practices, covering 41% of the population. In 1996, 31% of all GPs in England and Wales were women compared with 20% ten years ago. Over 50% of all GP registrars (trainees) are women (Jarrold, 1997/98, p74).

Employment position of GPs

The curious employment position of General Medical Practitioners goes back to before the beginning of the National Health Service. From the outset of the NHS they adamantly refused to be part of a salaried service. Instead they wished to retain their status as self-employed practitioners, prepared to offer their medical expertise and medical services to the National Health Service in return for payment on a fee, allowance, capitation and fee for service basis. Although self employed, they were, and still are part of the National Health Service, the vast majority have always contracted with the NHS, and as such are subject to certain controls and direction by statutory bodies such as the former Family Practitioner Committees, then by the Family Health Services Authorities, and now by Health Authorities. However, their "self employed" status remains and is regarded by many General Medical Practitioners as an important factor in their relationship with government.

They operate like a small business in some ways. They appoint and employ their own staff who are practice employees, not NHS employees. These practice employees have salaries, terms and conditions etc determined by the practice and not nationally determined in the same way as National Health Service staff, although from September

1997 all practice staff were allowed to join the NHS superannuation scheme (GPs had long been members of an NHS scheme). A large percentage of staff costs and certain other elements of practice expenses are funded by the National Health Service through the statutory body, the Health Authority, which is accountable to the Secretary of State for expenditure incurred in delivering general medical services.

In many respects GPs have always been doctor managers. This role grew as practices became larger. In these larger group practices they managed in the main, through the senior receptionist who looked after the day to day organisational requirements, i.e. making the best use of accommodation and equipment, financial control and preparing practice accounts, data collection and other statistics, maintenance of patient records, appointment systems, etc. (Drury and Collin, 1986, p242). Most GP practices held monthly partnership meetings within the practice, to determine practice policy and review the financial position of the practice. The management decisions of this meeting would be conveyed to the senior receptionist for implementation. Most of the staffing matters of the practice, i.e. secretarial and receptionist appointments and disciplinary matters affecting these groups of staff, as well as training and supervision of

administrative staff and domestic staff were handled by the senior receptionist. The appointment of other medical staff to the practice remained the responsibility of the principal and other partners, as was the supervision of doctors attached to some practices for training purposes under the GP Vocational Training Scheme.

The GP himself/herself retained direct involvement in meetings of external agencies, for example meetings of medical executive/advisory committees in the local hospital, and of the local medical committee of the then Family Health Services Authority. They were also often asked to act as assessors for medical appointments in other practices and on some health boards.

The traditional role of the GP could therefore be described as two fold. On the one hand he/she was a "personal" doctor, with face to face contact with his/her patients in the consultation process, on the other hand he/she was a doctor manager, managing the practice (with the administrative tasks delegated to an employee). This management role was, however, founded on a reactionary management style, reacting to problems as they arose with very little thought to a pro-active corporate model of primary care. Management, as in secondary care, was an exercise designed to secure the conditions necessary for

doctors to practice individual curative medicine. The difference in primary care was that the doctors owned the "business" and employed the administrators.

Review of Primary Care Services

In 1986, the Government decided to carry out a comprehensive review of the primary care services. A discussion document, "Primary Health Care; An Agenda for Discussion", was published in 1986 and set out the Government's objectives for the primary care services. These objectives included making services more responsive to the needs of the consumer and raising the standards of care. There was to be increased emphasis on health promotion and the prevention of illness with more patient choice and improved value for money. It was argued that clearer priorities needed to be set for primary care services in relation to the rest of the NHS (Secretaries of State, 1986).

The resulting White Paper, "Promoting Better Health", was issued in November 1987 with the main thrust of the document stressing the need to shift the emphasis in primary care, from the treatment of illness to the promotion of health and the prevention of disease (Department of Health and others, 1987). The emphasis at this point was on a shift within primary care.

The government considered that the best way of achieving this objective was to require practitioners to increase the range and quality of services they provide in three inter related ways. Firstly, no opportunity should be lost to increase fair and open competition between those providing Family Practitioner Services. Secondly, to that end, consumers should have readier access to much more information about the services provided. Thirdly, the remuneration of practitioners should be more directly linked to the level of their performance (Department of Health and others, 1987, p2).

So far as the general medical services provided by family doctors were concerned, the government outlined a range of measures which they considered would significantly improve these services. These measures were designed to overcome the wide variations in standards across the country particularly in the inner city areas, with insufficient team working in general practice, too many surgeries with unacceptably low standards, lack of advice from some practices on health promotion and so on. The overall government aim was stated as "to ensure a family doctor service which responds effectively to the needs of consumers" (Department of Health and others, 1987, p12).

The New General Practitioner Contract

Many of these reforms were introduced through a new GP contract. The new contract had implications for GPs as managers of their practice and as autonomous independent providers and heralded the beginnings of a new era of more positive management of primary health care by the NHS as well as expecting GPs to manage their practices in modified ways.

The new contract for General Practice in the National Health Service was introduced by the government in 1990 despite considerable and sustained opposition from the GPs. Details of the proposed changes to the GPs' terms of service and remuneration system were issued by the Department of Health and Welsh Office in February 1989. These proposals included changes in the basic practice allowance resulting in an increase in the proportion of GPs' income to be derived from capitation to at least 60%. In addition, in order to encourage continuing medical education there would be new training allowances which would continue throughout a GP's time in active practice. Other payments included those for teaching medical students, for isolated practices, for health promotion and health checks and increased payments for out of hours services. There were also changes making it easier for people to change their GP and to have information about

the practices (Department of Health and Welsh Office, 1989c).

Whilst the changes, including the new GP contract, were major and far reaching for all primary care services, they had a particularly important impact on the general medical services in that they paved the way for even wider and more radical changes which were outlined in the subsequent White Paper, "Working for Patients" (Department of Health, 1989). These changes initially included arrangements to enable larger GP practices to hold funds to purchase certain hospital services, the introduction of the indicative prescribing system for other GPs and the development of Medical Audit (Ham, 1991a, p8).

GP Fundholding

The qualifying patient size list in order to be eligible for fund holding status was originally set at 11,000 then reduced to 9,000 and further reduced to 7,000 for practices joining after 1st April 1993 (Glennister et al, 1994, p75). The main elements of the GP Fundholding Scheme at its introduction in April 1991 as outlined by Glennister et al were:-

- a) "Practices with more than 9000 patients in 1991 could apply to join the scheme. Regions drew up a list of criteria to screen applicants. The aim was to ensure that practices were managerially and technically capable of handling the

scheme and were committed to it.

- b) Practices received a budget allocation that could only be spent on a defined set of purposes. It could not be used to increase the doctor's income or to benefit the practice generally. This budget was not paid as cash to practices but held by the then Family Health Services Authorities and used to pay hospitals when a practice told them to do so."

(Glennister et al, 1994, p76).

Five main areas were covered by the budget, hospital in patient care for a restricted range of operations, all out patient clinics, diagnostic tests done on an outpatient basis, pharmaceuticals prescribed by the practice, and practice staff (Glennister et al, 1994, p76). In 1993 the scope of the fund was extended to include community health services, district nursing, health visiting, chiropody, dietetics, all community and outpatient mental health services, mental health counselling, and health services for people with learning difficulties. Terminal care and midwifery were however, at that time, still excluded as were some acute secondary services (Glennister et al, 1994, p76). The "community" extension added further to the power and control now vested in GPs. Previously they only had control over those professionals they employed, now this was extended to a centrally supported expansion programme, integrating into the primary care team a whole range of community professionals (Salter, 1998, p94).

In 1991 Ham considered, "The most significant innovation in primary care is the introduction of fund-holding practices" (Ham, 1991a, p62). "The fund holding scheme together with the new GP contract should encourage GPs to do more work for themselves and to reduce the demands made on hospitals" (Ham, 1991a, pp62-63).

The thinking behind these changes was that investment in primary care would produce a reduced demand for hospital care through the early diagnosis of a medical condition or indeed the prevention of the condition ever occurring in the first place through health promotion programmes (Salter, 1998, p94). In fact this was a similar trap into which the early architects of the health service fell, grossly underestimating public expectations of the health service, i.e. more health provision equals more (not less) public expectation and demand. In reality, in the opinion of Salter, "More primary care supply does not mean less secondary care demand." (Salter, 1998, P95).

For the GP doctor manager, the changes enabled GPs to pressurise their consultant colleagues in secondary care in a way which would have been unthinkable before fundholding (Salter, 1998, p97). The downside to this, so far as GPs were concerned was that their extended role

meant that the responsibility for rationing primary care and (through their "gatekeeper" role of restricting access to consultants only through the GP) the purchasing and rationing of secondary care, and with them the burden of these extra (and for the GP, totally new) responsibilities thrust upon them by the government, found the GPs ill prepared for, what were in fact, strategic management tasks. This was a major departure from the traditional face to face clinical consultation with individual patients, to much wider managerial considerations not restricted to their own practice.

Nevertheless the changes continued. In order to evaluate options for extending the list of services GPs were allowed to purchase, a range of pilot projects was established. This included 84 total purchasing pilots, involving 325 practices serving nearly three million people. Most total purchasing pilots were composed of several practices with a combined list size of 25,000 or more. There were six maternity pilots and thirteen mental health inpatient pilot projects (Health Service Journal, 1997, pp8-9).

In 1997 there were some 10,000 GPs in 3,000 practices managing their own funds, providing and purchasing services on behalf of almost 50% of the population. Some

GPs who did not wish to become fundholders, but who wanted to support each other, joined together in GP commissioning groups. These could advise health authorities, highlighting shortfalls in services (Health Service Journal, 1997, p9). By 1997, there were three types of fundholding, Standard, Community, and Total Purchasing (Health Service Journal, 1997, p8).

The purchasing role of practices became an integral part of the new NHS. As contracts became more sophisticated, those GPs granted fund holding status found themselves in a key position since budget holding conferred a power and authority to dictate the services they required for their practice population. This was not only in the range of services to be made available, but also in the standard and quality of services, and the price the practice would be prepared to pay for these services.

Whilst, as stated earlier, the emphasis in the 1980s had been on a shift within primary care, these changes in "Working for Patients" led to a much more radical shift i.e. a change in emphasis from the secondary care provided by hospitals, to primary care provided in the community. A major implication of this was the changed relationship which then took place between the hospital consultant and

the GP which has significant management implications. No longer was the GP subservient to the hospital consultant, the pendulum had swung the other way!

Once GPs held the budgets that were crucial to the financial viability of provider services, the new found power of the GPs and the change in professional relationships between GPs and hospital medical consultants manifested themselves in a number of ways. Things that had angered GPs for years, for example, delays in notification of outpatient appointments, long waits in hospital clinics, lack of information for patients and delayed discharge summaries, why were patients so rarely involved in decisions about their medical treatment, these matters could now be addressed. Many commentators asserted that it was because of fundholding that matters such as this were being tackled (Roland, 1992, p1). In the words of Roland, in support of fundholding GPs, "If you want to know where the power lies, look at who is signing the cheques to pay for hospital services. And power to improve quality of patient services is what it's all about" (Roland, 1992, p1).

The changes meant freedom for practices to develop different corporate structures and the encouragement of private finance in the development of primary care

facilities (Winkler, 1997/98, p163). In the opinion of McCulloch and Ashburner "Fundholding and other primary care initiatives have shaken up previously unresponsive secondary care services, refocused and improved management in primary care" (McCulloch and Ashburner, 1997, p22). However, in the opinion of McCulloch and Ashburner, the gains from the primary care policy have failed to address public health issues, or the problems of inequality and access to services. It also puts pressure on human resources. In addition, few GPs are trained in commissioning, resulting in confusion in their role (McCulloch and Ashburner, 1997, p22). These two authors consider that the primary care led policy has divided the NHS family by confronting secondary care, exacerbating the deep-rooted competitiveness between GPs and consultants and working against alliance building (McCulloch and Ashburner, 1997, p22).

In addition, whilst the power of GPs increased as they became managers of health service budgets with which they purchased/commissioned services from providers, there was also an increased management of GPs as providers of services, FHSAs became responsible for the strategic planning of primary care, the monitoring of indicative prescribing budgets, audit in primary care and so on. All these could be seen as subjecting GPs to more managerial

control and reducing their clinical autonomy. Individual GPs who have not involved themselves in management had to respond to decisions taken by their colleagues in fundholding practices. Also, the government, in a subtle way, virtually delegated aspects of rationing health services to fundholding GPs by asking them to work within fixed budgets for the secondary care they purchase and the drugs they prescribe. Also Health Authorities, who lacked formal authority to ensure Fundholder compliance with NHS financial controls, were seeking to develop informal methods of ensuring Fundholder accountability, in effect trying to "manage" GPs through financial control (Salter, 1998, p97).

Practice Managers

The relatively new grade of Practice Manager, was established in many practices in the 1980s to assist with increased workload. The advent of fundholding (in those practices granted this status) added substantially to these tasks. Practice Managers have a much wider role than the previous practice administrator, who was usually the senior receptionist. The Practice Manager, particularly in a fund-holding practice, had to take on increased responsibilities, not least of which were the preparation and negotiation of contracts with local hospitals and other provider units who provided the

secondary care services the practice required for its patient population.

More information was required, more statistics, increased monitoring of performance, patients needed to be better informed of the services the practice offered, health needs assessments needed to be carried out to try and determine which services the practice should purchase, mortality and morbidity rates had to be calculated, immunisation and screening targets to be achieved, there were more complicated methods of payment for the GPs, complaints procedures to be drawn up, and so on.

The debate over whether an NHS manager in secondary care could be, in Alford's terms a "challenging interest" was discussed in chapter 4. It was even more unlikely, however, that the practice manager could ever function in this way. This was primarily because he/she was appointed and employed by the GP, not by the NHS. This gave him/her a subordinate role to the GP. In addition to the practice manager, some large practices now have accountants, personnel officers and other administrative staff. The practice manager and the administrative team however, act in a supportive way to the GP, similar in many respects to the way the pre-Griffiths manager in secondary care acted (see chapter 6). The establishment of

practice managers has not necessarily detracted from the managerial role of the GP, indeed it could allow the GP to adopt a higher managerial profile since it released the GP from much of the time consuming administrative tasks. In the opinion of Keeley, the emphasis for the GP would now be less on "personal primary and continuing care of individuals and their families and more on organizing the work of a team of (hierarchically inferior) health workers" (Keeley, 1992, p31). This entails deciding how the money for the health care of practice patients should be spent and keeping that expenditure within limits (Keeley, 1992, p31). In addition, there was pressure on GPs to "think strategically" - eg formulate business plans, carry out practice profiles, engage in and utilise health needs assessments. This responsibility for resource allocation was a new venture for the fundholding GP, an extension of the new found managerial role.

This however presents the GP with a dilemma relating to his/her values as a doctor versus the new role of controller and allocator of health care resources (Keeley, 1992, p31). The individual patient consultation and treatment, which is the cornerstone of GP practice, has now to compete with wider practice population considerations.

My fieldwork research focuses mainly on secondary care. However, it also suggests (see chapter 7, p277) that GPs were not prepared for these vast changes which were imposed upon them by government. As one of my GP informants stated, "I have not had one hour of management training", yet he was required to be involved in virtually all aspects of management from the appointment of staff, negotiating contracts, managing and controlling budgets, policy making, operational and strategic planning, etc as well as the medical care of his patients, whose demands and aspirations were increasing all the time.

My GP informant was not unique in this regard. Almost no GPs have had any management training which would have made them better equipped to deal with the increased managerial workload mentioned above.

Further changes

A White Paper, "Primary Care: Delivering the Future" was published on 17th December 1996 and, in March 1997, The NHS (Primary Care) Act was passed, embodying most of the proposals contained in the White Paper (Department of Health, 1997). The most relevant part of the White Paper and other 1996/97 Primary Care documents for this thesis is the vision of a "primary care led" NHS. The increased emphasis the government attaches to primary care and the

vision of a primary care led NHS requires management as well as clinical skills. GPs have simultaneously become more managed (in relation to their provision of primary care) and more powerful managers (in relation to the increase in employed/attached staff, control of budgets and role in purchasing). The self employed status of the GP suggests that only the GP can undertake the management and the clinical role effectively. In a general practice, only the GP has the power and the authority to do so because he/she is the employer. The practice manager can create the environment within the practice for the GPs to carry out their clinical tasks, but the practice manager cannot effectively take and implement the strategic decisions which affect the internal operation of the practice or indeed take decisions affecting primary care in the wider sense, as these are the domain of the GPs.

Clearly not all GPs want to be involved in management. Some have neither the skills or the inclination to be involved in this way, nor would it be desirable for them all to do so. However, within a practice there is now a need for at least one of the partners to be heavily involved in the strategic management of the practice and to be able to view, and

have an opinion about, the wider perspective of primary care in his/her locality.

General Election 1997

The Labour Party, which was committed to abolishing fundholding, won the general election of 1997 with a large majority, and on their first day in office announced, as promised, that they would abolish the internal market as soon as practicable, although according to Klein, "The internal market died long before Labour pronounced its obituary" (Klein, 1997, p37). In its place would be installed a system of GP commissioning by grouping practices (Primary Care Groups) with plans to pilot new approaches to commissioning health services.

The new Labour government invited applications from commissioning groups and Health Authorities to submit joint bids to take part in the programme for twenty primary care-led commissioning pilots to start on 1st April 1998 and run for two years. They are based on existing GP commissioning groups which are recognised under fundholding regulations and have access to a prescribing budget. Health Minister Alan Milburn said, "The pilots will map out a new direction for primary care-led commissioning where co-operation rather than competition is the key" (Milburn, 1997a, p4). By April

1999, all practices will be organised into primary care groups and begin to take on the commissioning role.

Elsewhere I have outlined definitions of power and authority, as they apply to secondary health care. However, the management of primary care by the GP manager does not suffer from the same problem as secondary care in relation to the split between power and authority, i.e. power in the hands of the medical consultants, authority in the hands of the chief executives, which I have argued in this thesis, weakens the thrust and direction of health services. In primary care there is no such split, power and authority are firmly in the hands of the GP despite some moves towards the management of primary care by the Health Authorities. Indeed it would appear that there is now official recognition, at least in primary care, that when power and authority rest in the same hands they can be extremely effective. This is evidenced by the increased emphasis on the importance of the GP in being actively involved in management, with added importance given to nursing and other members of the clinical health care team, i.e. those professionals closest to the patients. The whole practice team is under the direction of the GP who is also their employer or the purchaser of their services. This gives the GP considerable power and

authority over the direction and development of health services in that locality.

The rapid expansion of primary care services and the associated shift to a "primary care led NHS" present general medical practitioners with a unique opportunity to take the lead and become more formally involved in the management of these expanded services. One of the main difficulties however is that very few general medical practitioners have any formal management training to equip them to manage these new-multi function general medical practices. In addition, as my fieldwork research shows, very few general medical practitioners wish to get involved in the wider strategic management and planning of general medical services and other health services e.g. through commissioning groups.

Fundholding conferred on general medical practitioners considerable power and authority in order that they be key players in the shift from secondary to primary care. This manifested itself in a significant change in the relationship between the hospital consultant and the GP. Insufficient thought however, was given to the enormity of the task for general medical practitioners and even though GP fund-holding was quite generously funded, the extra workload generated by these changes and

by the considerable expansion of services was grossly under estimated. To a large extent, practice managers have taken on board the day to day running of practices and provide considerable support to the GPs in an environment maintenance role. However, they lack the power to take and implement strategic decisions which shape the thrust and direction of primary care health services, particularly as these decisions impinge on doctors, and to lesser extent, other clinical professionals working in the practice.

This enhanced management role also presents a time management problem for the GP and other clinicians, not unlike the time management problem of doctors in management in secondary care. As in secondary care, to remain powerful and influential the GP manager must continue to be heavily involved clinically. For the GP manager, this means continued involvement in the cornerstone of GP practice; the individual patient consultation. This leaves precious little time for the management role and as such is a problem that needs to be addressed.

This chapter has examined the changing role of doctors in primary care and how this changing role has implications for the management process, not only in

primary care but also in secondary care. Marnoch is right in saying that "GP fund-holding fundamentally changed the professional relationships between GPs and hospital consultants" (Marnoch, 1996, p35). The enhanced position of the GP, in clinical and in managerial terms, now has official government blessing, and places the GP in the driving seat when looked at in terms of the future shape and direction of health services. The expansion of primary care services is a clear indication of the way the government is refocusing the NHS on a public health agenda (Hunter, 1998, p36), enhancing the role of the GP and other community based clinical professionals. This has important implications for the evolving role of doctors in management in both primary and secondary health care. The managerial role of GPs on the locality purchasing groups and GP commissioning groups which are replacing GP fundholding is an important one since it involves taking part in strategic decision making determining the shape and direction of health services in that locality. The role of the GP in managing an ever expanding practice and practice team is a managerial role within the practice which is unprecedented, similarly the extent to which the GP himself/herself is being managed is quite unique.

In the next chapter I shall examine approaches to

medical management and to the clinical directorate systems which have been adopted in the secondary care sector of the health service.

CHAPTER SIX
MANAGERS AND DOCTORS IN SECONDARY CARE

The previous chapter discussed the managerial role of GPs and the rapidly changing pattern of health care in the primary sector. This chapter will examine the various approaches to management in the secondary care sector including discussion on the pre-Griffiths manager and the position of the manager after Griffiths. A discussion on the power/authority divide and on the dilemmas faced by doctors as they become involved in management is included, as is, in a climate of rationing, the question of the doctors' value position and their use of clinical resources. An examination of the Clinical Directorate system, which is a favoured option for involving doctors in management in the secondary care sector, is also included in this chapter.

The more efficient use of clinical resources has been a goal of successive governments and health service managers throughout the 50 year history of the NHS. The

more active involvement of doctors in management can be seen as a further attempt to address this problem by utilising the clinical expertise, influence and standing of consultant medical staff to help to persuade their colleagues to bring this about. My argument is that the blend of power and authority which is essential in the management of any organisation can only be achieved by having doctors actively participating in the formal management process and thus optimising the use of clinical resources. I would argue that the failure to recognise the importance of this blend of power and authority at operational level, mitigates against this effective use of clinical resources and has contributed significantly to the reason why so many of the NHS reorganisations and reforms of the past have not brought about the improvements and desired effect they were designed to produce.

Managers before Griffiths

Before attempting to examine the differing approaches to management by doctors and their professional relationship with managers, it is important to understand the historical background and the "official" position and role of National Health Service Managers before 1983. A very small minority of these managers had a medical, nursing or other health professional background, the large

majority of administrators/managers were male, and most held a managerial qualification with the then Institute of Health Service Administrators.

The National Health Service manager's role prior to 1983 (i.e. prior to the Griffiths Report which introduced General Management) contrasted sharply with the role one would expect of a senior manager in an organisation outside the National Health Service. In any organisation even a fraction the size of some hospitals, one would expect the senior manager to have an executive role over the whole of the organisation with considerable authority in at least the areas of decision making, budgetary control, resource management, staff management, customer relations, quality control, strategic planning, and capital expenditure. One would expect such a manager to be top of a hierarchical structure with wide powers, considerable authority and as a consequence, high levels of responsibility and accountability.

This, however, was not the role of the pre-Griffiths health service manager in the years up to the mid 1980s. Alford, writing of the health care manager in New York, and outlining his "structural interest theory" suggests that whenever the words, co-ordination, strategy, information systems, efficiency, integration, evaluation,

appear in any health care setting, there you have the health care manager, or in his terms, the "Challenging Interest" group, the corporate rationalisers (Alford, 1975, p183). However, the views of Alford of the managers being the interest group which challenges the dominant medical interest, are at variance, Harrison et al argue, (Harrison et al, 1990, p158) with the official view of the pre-Griffiths NHS. Alford's views of managers would seem to be more appropriate to the post Griffiths manager in the context of the NHS.

The official view of the pre-Griffiths manager has been expressed over the years in various official documents and by various senior Ministers. These pronouncements, examples of which are shown below, clearly demonstrate that the role of the National Health Service manager at that time was not that of a "challenging interest", but more a subservient role to medical staff, deriving from the all important maintenance of "clinical autonomy":

- i) "Whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of patients in the way in which they feel to be best."

(White Paper, "A National Health Service", Ministry of Health, 1944, p26)

- ii) "The service should provide full clinical freedom to the doctors working in it."

(Crossman Green Paper. The future structure of the National Health Service. Department of Health and Social Security, 1970, p1).

iii) "The organisational changes will not affect the relationship between individual patients and individual professional workers...(who)...will retain their clinical freedom...to do as they think best for their patients."

(Joseph, White Paper. National Health Service Reorganisation: England. Department of Health and Social Security, 1972a, pvii).

iii) "Success...depends primarily on the people in the health care professions who prevent, diagnose and treat disease. Management plays only a subsidiary part."

(Grey book. Management arrangements for the reorganized National Health Service. Department of Health and Social Security, 1972b, p9).

iv) "It is doctors, dentists and nurses and their colleagues in the other professions who provide the care and cure of patients...it is the purpose of management to support them in giving that service."

(Patients First. Department of Health and Social Security and Welsh Office, 1979, pp1-2).

(cited in Harrison, Hunter, Marnoch, Pollitt, 1989b).

However, some writers of this period have found Alford's analysis useful. Ham, in his study of the Leeds Regional Hospital Board's activities during 1947 to 1974 considered, "Alford's discussion of professional monopolisers, corporate rationalisers and the community

population has been the most useful way of conceptualising the different interests involved." He agrees with Alford, "That the conflicts between these interests are not best seen as a struggle between pressure groups in a pluralist system. Rather, the important point to note is that the dominant interest - the professional monopolisers - is systematically benefited by the status quo" (Ham, 1981, p199). Harrison, et al, however whilst agreeing with Ham that an underlying theme of successive reorganisations has been a higher managerial and financial profile, of which doctors have been aware, considers that it is only during the 1980s that the challenge to doctors has acquired substance. It became more focussed and more confrontational, whereas earlier management stressed consensus and a collegiate relationship (Harrison et al, 1990, p158).

Before Griffiths, the senior NHS manager was not expected to perform some of the tasks one would normally expect of a manager of a large organisation. He (the large majority of NHS managers at this time were male) was not top of an organisation-wide hierarchical structure. He did not challenge the medical interest, as Alford suggests, indeed as late as 1979 the legitimate role of the manager was defined in official literature as one of "organisational maintenance", smoothing out internal

conflicts and providing facilities for health professionals (Department of Health and Social Security, 1979, P1, cited in Harrison, Hunter, Marnoch, Pollitt, 1989b). Certainly there appeared to be no challenge to the dominant medical interest in that type of role, contrary to Alford's view.

It could be argued that a different context prevailed in the mixed economy of healthcare in the USA for, as well as there being more managers who were also doctors, there was a much earlier emphasis on contracts, billing, securing and keeping business etc than in the NHS. Thus in the USA, doctors were expected to account for themselves more.

The NHS manager lacked power, but he could also be seen to have weak authority. He was not accountable in the same way as a manager would be in other organisations. An important ingredient with which he had to cope was the unique element of clinical autonomy exercised by medical consultants and backed by official pronouncements from the Department of Health. In addition the "political domain" placed (sometimes conflicting) demands on managers. The task of the NHS manager was that of a peace maker, "a fixer", ever trying to harmonise the workings of a very complex organisation in order that the clinicians, in

particular medical staff, had a sound base from which to practice their clinical skills. His role was to produce an ordered state within the hospital, in which the various departments and professional staff of all persuasions could perform their tasks. The absence of a pro active element in the role of the pre-Griffiths manager to shape plans, initiate action, manage the total organisation, and take strategic decisions is evidenced by Haywood in a systematic classification of all agenda items on several management teams in 1979. Haywood's findings demonstrate the prevalence of non strategic items: 90% of agenda items related to information exchange and deciding to whom issues should be referred, rather than action on matters of strategic importance to the organisation. Haywood summarised chief officers, i.e. the "managers", as "directors of process... people who reacted to situations rather than initiating action" (Haywood, 1979, pp54-59).

According to Harrison et al, "The pre-Griffiths management culture of the NHS can thus be described as "diplomacy", in which managers were not expected significantly to influence the nature or direction of the service (Harrison, Hunter, Marnoch, Pollitt, 1989). They argue that the pre-Griffiths manager could not be seen as the "challenging interest", in the way Alford portrays the health care manager. The pre-Griffiths manager is seen

as more of a diplomat than a catalyst for major change. "He was concerned not to procure major change in the shape of the health services, but rather to minimise internal conflict and to facilitate the work of the health care professionals" (Harrison, 1988, p30).

In many instances, Harrison considered that the pre-Griffiths manager also became a scapegoat when things went wrong. He argued that from 1982 the diplomat role of the NHS manager was being eroded and managers were increasingly being blamed by the Government for the shortcomings of the service. At the same time, new initiatives suggested that a challenge to the medical profession was taking place and there was an attempt to shift the frontier of control between government and doctors by detaching managers from the "provider" category and converting them into agents for the third party, the government itself. There were arrangements to improve accountability, with such initiatives as the review process, Performance Indicators, Rayner scrutinies in the areas of vacancy advertising, storage of supplies, catering costs, reviews of the cost effectiveness of meetings, the sale of NHS residential property, collection of income due to Health Authorities etc, together with value for money initiatives and the introduction of competitive tendering (Harrison, 1988, pp56-57).

Between the late 1960s and 1982, according to Harrison et al, there were some 25 empirical projects on the management of the National Health Service, providing a remarkably consistent picture embracing the behaviour, attitude and beliefs of National Health Service staff, and representative of the pre-Griffiths NHS (Harrison, Hunter, Marnoch, Pollitt. 1989a).

The research projects which were carried out reinforce the view that the National Health Service manager's role was to support the work of health care professionals. According to Harrison the conclusions fell basically into four categories:-

- i) Managers were not the most influential actors in the NHS (pluralism).
- ii) Managerial behaviour was problem driven rather than objective driven in character (reactiveness).
- iii) Managers were reluctant to question the value of existing patterns of service or to propose major changes in them (incrementalism).
- iv) Managers behaved "as if" other groups of employees, rather than the public, were the clients of the NHS (introversion).

(Harrison, 1988, p31).

This interest in empirical research in the National Health Service began in the run up to the 1974 reorganisation, with most of the research focussing on

relatively senior levels of management (Harrison, 1988, p31). Findings from a number of these research projects emphasise the extent to which medical involvement influenced the decision making process. For example in a study carried out by Rathwell in one health authority, attempts to decide the number of hospital beds for the elderly remained unsuccessful as a result of medical disagreement over a period of four years (Rathwell, 1987). In examining these studies, one needs to understand the considerable political pressures under which the pre Griffiths manager worked (whether this changed post-Griffiths is a matter to which we will return).

Traditionally the main power base in hospitals has been the medical staff. Alford recognised this in his study when he refers to the medical staff as the "Dominant Interest Group" (Alford, 1975, p14). The unique position of consultant medical staff was such that they occupied a powerful position in the organisation, and yet were not even employed at that time by the local hospital. They were employed by the Regional Health Authority by whom they were appointed and who held their contracts of employment, although these contracts specified working in a particular hospital. To have a group of people who are the organisation's largest spenders and have enormous influence over the patterns of work and services delivered

but who are not appointed by, not employed by, nor accountable to the organisation, leaving the local manager with little or no control over their actions, clinical and non clinical, was a situation unique to the health service. Little wonder the NHS manager could not be seen as challenging the powerful medical interest. Indeed, Brown considered, "The single most important weakness in the organisation and management of the NHS is the persistent failure to find an adequate conceptualisation of the relationship of clinicians to management" (Brown, 1979, p218).

A study by Schulz and Harrison, who studied 18 management teams in the era of consensus management, found that:-

- i) On 12 teams there was overwhelming agreement that consultant medical staff had the primary influence on the pattern of health care in the area.
- ii) Only two teams of managers (or "management teams") ascribed the primary influence to themselves.
- iii) The remaining four were either divided on the issue or ascribing equal influence.

(Schulz and Harrison, 1983, p33).

In summary, the research findings portray the reactive, incremental and introverted character of pre-Griffiths management, largely producer-orientated rather than

consumer-orientated, responding in the main to internal problems rather than those raised by patients, relatives or community representatives (Harrison et al, 1989a, p7).

The manager therefore acted, indeed had to act, in a pluralist setting, in which he was only one of a considerable number of people (e.g. health authority members, consultant medical staff, senior finance staff, senior professional staff, not to mention the Department of Health, Regional Health Authority and others who had a real say in many of the matters under consideration), with the overwhelming influence at the local operational level coming from the consultant medical staff. From 1974 until the Griffiths recommendations were implemented in 1986, he operated in a team whereby consensus decision making was the rule, although in practice, medical influence still seemed to dominate. This is also in direct contrast to that of managerial authority in most business like organisations. Indeed in an extract from a Health Circular on Structure and Management, HC(80)8 the following paragraph demonstrates the curious role of the manager "who does not have any managerial authority over other chief officers."

"In a service as complex as the NHS and comprising so many different independent disciplines and functions there must be clear arrangements for administrative coordination, which are understood and accepted by all. This will be the responsibility of the

District Administrator. This does not give him any managerial authority over other chief officers, but it does impose on him a responsibility to see that an account is provided to the authority on how its policies and procedures are being implemented. He will also be responsible for ensuring that individual responsibility is identified for each piece of action which the authority requires to be carried out."

(Department of Health and Social Security, 1980).

Having received a government circular of this kind, it was easy for a NHS manager to conclude that not only was he devoid of power, especially so far as doctors were concerned, but also there was considerable doubt as to whether or not he was vested with any authority! The role of the pre-Griffiths manager was therefore a difficult and much misunderstood one. He was often criticised for things he was not expected to do nor indeed had the power or authority to do. His role was not to promote major change, not to challenge the medical interest, not to interfere with clinical autonomy, but more, as Harrison puts it, to be a diplomat, or to be a scapegoat for things that did not go according to plan (Harrison, 1988, pp30-56). He was an all-party politician, expected to implement new legislation, new policies, new systems and procedures, and to create and maintain the environment in which clinicians, in particular medical staff, could carry out their clinical tasks.

The health service manager was seen as contributing to patient care in the main, by way of his support for medical staff and other clinical professionals. They had the face to face contact with patients, and the manager provided the means by which they were able to practice. The pre-Griffiths manager thus tended to react more to situations and problems as they arose rather than taking a pro-active approach. Problems appeared on his desk and his job was to resolve the problem and get the organisation working once again in harmony. This was not to say the pre Griffiths manager had no influence over the working of the organisation, indeed as I shall argue, he was in an ideal position to exert great influence in a considerable number of ways. The way in which he did this however varies greatly from the way one would expect a senior manager to operate.

Having observed at first hand the management systems in operation at that time, the influence of the pre-Griffiths manager lay in his, in many instances, considerable ability to persuade members of the Health Authority, consultant medical staff, and other senior staff to his way of thinking. Whilst at this time he lacked the formal authority one would expect of a senior manager in a large organisation, his great strength lay in the fact that he alone was the person with an overall

knowledge of the whole of the organisation. He didn't know everything that was happening, but he knew more than anyone else. He had access to budgetary and other information about every department and knew how decisions would affect different departments in different ways. He was at the management head of numerous departments scattered throughout the hospital and considerable numbers of staff were ultimately responsible, through junior managers, to him. Herein lies one of his major influences which is often understated, in that he was in a prime position to be a staff motivator, a task carried out by some pre-Griffiths managers with a high degree of success.

He often had to "sell" health authority decisions which had advantages for one department, but which had adverse consequences for another. His knowledge about the organisation meant that senior staff were reluctant not to follow his advice. He had of course to "get it right" most of the time. He would quickly lose his credibility if his advice proved to be wrong on too many occasions.

Some of the literature describing events of this time paint a picture of a conflict situation between doctors and managers in the years before Griffiths i.e. before 1983. My own perception however, based on personal

experience is that the supposed conflict between doctors and managers, or as they were then called, administrators, was (and in my opinion, still is), much over stated. In many instances, doctors and managers worked in a harmonious relationship and when this happened a dynamic and pro-active style could emerge. I would question the text book image of continuous conflict between doctors and managers at this time. It is true the manager had to adopt a different style in his dealings with doctors as opposed to other grades of staff, i.e. he was not a challenger in Alford's sense, but a shrewd manager could turn this to advantage and reap the rewards of a good working relationships with doctors which was to the benefit of the whole of the organisation. Of course the very fact that the manager had to work in this covert way is evidence of his lack of power, rather like women's ways of "managing" husbands in a patriarchal society!

For all its faults this system steered the health service from its inception in 1948 to the early 1980s. At that point, the health service, although as always struggling financially, was still regarded by many as providing a health care system as good as any in the world. However, in the opinion of the government of the day, it needed to be radically reformed in order to produce better value for money services, more consumer

choice, and to equip it for the next century, whilst still maintaining its basic principles of equity and access. As discussed in chapter three, the introduction of business like systems of management and organisation and the introduction of market forces and competition were seen as the way forward.

Managers after Griffiths

As described in chapter two, the implementation of the Griffiths Report in 1985 had a direct and major influence on the organisation and management of services, and on all other grades of staff, but it did little to diminish the power of medical staff. In considering the extent to which new style General Managers eroded medical autonomy in the early post-Griffiths years, Harrison et al concluded, "There is little sign of change in doctor-manager relations. They continue to inhabit a shared culture of medical autonomy in which rarely do managers challenge clinicians" (Harrison et al, 1989a, p38). Indeed a major study carried out by Harrison et al between 1987 and 1989 concluded, amongst other things, that so far as medical staff were concerned, "The frontier of control had only slightly shifted in favour of management" (Harrison et al, 1992, p71). Strong and Robinson also concluded that:-

"Griffiths, for all its radicalism, was only a partial break from the past. There was now a

chain of command which reached from the top to the bottom of the organisation. There was also a new headquarters staff with a potential flexibility to match the exigencies of local need and form. But the service was still trapped, for general managers at least, within a straightjacket. Local initiatives were frustrated by ministers, by civil servants, by supervisory management tiers and by professional bodies. Doctors still gave orders, nanny still knew best."

(Strong and Robinson, 1990, p164).

Strong and Robinson point to the way that the authority of managers was weakened by political and bureaucratic controls as well as by the power of doctors. The relative weakness of management, which, according to the findings of Harrison and his colleagues, and others, was not rectified by the introduction of Griffiths-style general managers, does help to explain the late 1980s (pre "Working for Patients" reforms) management style of the NHS. One is left with the feeling that the Griffiths-style general managers and Chief Executives did little to challenge the power of the doctors, especially at the operational level. The introduction of general management to replace consensus management underestimated the power of the Medical Consultants, and there remained a divide between the power of the consultant and the authority of the manager. It could be argued that this weakened the thrust and direction of the organisation.

The changes which were happening throughout the

health service had profound implications for its organisation and management. However, so far as medical staff were concerned their power and dominance continued, backed by the considerable influence they exerted through their membership of powerful national and local committees.

Background to doctors involvement in management

Budgets, staffing matters, motivating people and strategic planning are hardly the issues with which doctors in the NHS would, in the past, have been considered to be centrally concerned. The traditional role of doctors is seen as dealing with the molecular pathology of disease, replacing heart valves, tending to the dying or being instrumental in some major breakthrough in medical science. Indeed the old view of management for doctors was that this was an area in which doctors who were too old and burnt out for anything else could operate (Smith, 1995, p1). The "failed clinician" tag was often attached to doctors who decided to practice the art of management and, as such, these doctors in the formal management process were viewed with suspicion, not only by managers, but also by other doctors and their influence was limited.

However, as we have seen in previous chapters,

doctors have been involved in the organisation and management of the NHS from its very beginnings, albeit in a variety of ways. It has already been argued in this thesis that the reluctance of doctors to be formally involved individually in the management process over the years stems largely from the fact that, prior to the NHS Reforms following the 1989 White Paper, "Working for Patients", doctors were able to sufficiently influence decision making through their local and national committees and their professional bodies without having to be involved more directly. They also had a high degree of individual autonomy. However, recent changes have increased the incentives for doctors to be formally involved in management on an individual basis.

There have been mixed reactions, especially amongst doctors themselves, to this formal involvement in management. Previously, many senior doctors had adopted a very real interest in the power politics of management to bring about change, to set the direction of the service and to preserve clinical freedom, but they had always backed away from this involvement whenever attempts to hold them accountable for resource use or attempts to curb individual clinical freedom had emerged.

There was therefore always interest in "informal"

management, but their involvement as individuals in formal management was a new, and as my fieldwork research shows, even a frightening prospect for some doctors (see chapter 9, p355). For example, many doctors themselves doubted whether their training, which stressed their professional aim was to provide the best possible care for their patients without consideration of cost or the financial implications of a particular course of clinical treatment, would equip them for this new role. They thus had the dilemma of their "value" position as a doctor treating the individual patient, versus the wider collectivity of patients (and taxpayers') interests which it would be necessary to consider in a management role.

A whole range of new skills would have to be learnt, in addition to the communication, teaching and counselling skills relevant to management which may have been acquired during medical training. Not least in this was the widening of perspective mentioned above. In addition, there would be the task of motivating and providing leadership to a large work force, many of whom were professionals in their own right with considerable skills and a degree of autonomy. They would certainly not be the easiest of work forces to manage.

Doctors and Management at the local level (pre mid 1980s)

Up to the mid 1980s, in a managerial context, at local level senior doctors had what became known as "Cogwheel divisions." The Cogwheel system was established in 1967 following recommendations from a joint Ministry-General Medical Council committee that a specialty division structure be set up as a basis for medical representation on Medical Advisory Committees (MACs). (Marnoch, 1996, p17). The Cogwheel system was used as a basis for sending the "senior" doctor of each clinical division to represent the division on the MAC and was intended to be a system to give doctors more information about the effects of their decisions (Salter, 1998, p20). However, as Marnoch points out, implementation of the Cogwheel recommendations was haphazard and was a development which, in his opinion, "headed off, rather than confronted, the old problem of lack of articulation between strategic, locality and operational management in the NHS" (Marnoch, 1996, p20), thus allowing the medical profession to remain "adrift of managerial control from the higher levels in the NHS organisation." (Marnoch, 1996, p20).

The MAC was made up of representatives of the Cogwheel specialty divisions employed in the hospital(s) together with GP representatives from the Local Medical Committee. Marnoch stated that these MACs "In effect

represented the medical constituency within the hospital or group of hospitals it served. Its chairman was the medical profession's symbolic figurehead" (Marnoch, 1996, p20). There was usually a place on the Committee for a representative of the junior doctors employed in that particular hospital, but never a formal seat or vote on the committee for management, although the chief officer was often invited to attend for certain parts of the meeting, purely in an advisory capacity.

The Medical Advisory Committee was a very powerful committee, proffering advice to the formal management of the hospital(s) on a variety of clinical and indeed non-clinical matters affecting the organisation and management of the hospital(s) and its associated community health services. For example, whilst this committee was not usually part of the budgetary allocation machinery, it was normal for block financial allocations to be made available to the committee for them to advise on how they considered that money ought to be used. An example of this would be in the budget allocated for medical equipment, usually running into many hundreds of thousands of pounds even in a small health district.

Prior to the establishment of clinical directorate systems in many hospitals in the 1990s, as can be seen in

Appendix VI (Traditional Hospital Organisation Structure), the MAC operated quite separately from the other staff disciplines. In addition, individual consultants, and the junior medical staff working with them, had a system of "firms" as they were sometimes called and these "firms" retained clinical autonomy/freedom to carry out clinical tasks independently. Their's was the face to face contact with patients and any attempt by management to influence this relationship was dismissed as unwarranted "managerial interference." Clinical autonomy bestowed "unmanageable" status on consultant medical staff (Williamson, 1988, p171).

The effects of the "traditional" structure mentioned above meant that the integration of services, and as such managerial control, was virtually impossible. This was because management was based upon functional disciplines and focussed on staff inputs, and therefore tended to be introverted, this approach fragmenting the approach to treatment and making treatment processes all the harder to manage. At this time, (early 1980s) accountability for the staff disciplines of nursing, finance, administration, personnel etc flowed upwards via Unit Officers to the Unit General Manager, but representative accountability for medical staff moved downward. The effect of this, according to Packwood et al, was that the structure relied

upon communication via hierarchical chains of management or transmission by the medical representatives. This resulted in problems combining the aggregate and strategic approach required for unit-level resource management, with the detailed operational approach required in providing services to individual patients. Although other staff were accountable and ultimately responsible to the unit general manager, accountability in the medical profession moved downward fragmenting out to individual clinicians based upon personal power rather than managerial authority (Packwood et al, 1992, pp68-70).

The above analysis of Packwood et al alludes to my argument about the problems caused by a split between power and authority. Following the implementation of the Griffiths recommendations the non-medical general manager possessed both the managerial authority and power which allowed him/her to manage the organisation, except when it came to the management of consultant medical staff. This was the point at which the power/authority split became apparent. The non medical manager lacked the power to manage medical staff and to change inefficient clinical practice where this existed. Since medical staff were the organisation's largest spenders and committed the vast majority of the resources it followed that the non management of this group of staff resulted in

fragmentation, failure to make the best use of clinical resources, and a weakening of the organisation's overall thrust and direction. Elsewhere in this thesis I shall return to this problem and attempt to suggest a framework in which authority and power can be merged, thus avoiding the problems outlined by Packwood et al above.

As we have seen (see chapter 2, p45), at national level the medical interest has been served in a variety of ways through professional bodies. The British Medical Association, The Consultant Specialist Association, and The Royal Colleges, together with a very complex and powerful lobbying system, gained medical staff access to decision makers and powerful individuals and interest groups. The powerful medical interest at work nationally accords very well with Alford's concept of doctors as "professional monopolisers" within his Structural Interest Theory (Alford, 1975, p19) (see chapter 4). Indeed one of the strong points which supports the theory is that very often the medical interest is perceived to correspond with the interests of the general public and their representatives. (Williamson, 1988, p171).

The growing political pressure for doctors to become more involved.

The trends in management styles from about the mid

1980s and leading up to the 1989 White Paper, "Working for Patients", had been considered by leading commentators as "the beginning of a new era", intending to change the managerial and professional culture of the NHS throughout the 1990s (Day and Klein, 1989, pp1-3). Both the 1983 Griffiths Report and the 1989 White Paper "Working for Patients," illustrate increased interest in the involvement of doctors in management, Griffiths, concerned to improve decision-making in the NHS through strengthened managerial accountability, recommended that:

"Clinicians must participate fully in decisions about priorities in the use of resources" (Griffiths, 1983, pp18-19).

The White Paper echoed this view:

"The government welcomes the increasing willingness of hospital consultants to assume managerial responsibility. It wishes to extend and strengthen medical participation in management so that the profession can contribute more effectively to decision making and so influence the future direction of services."

(Department of Health and others, 1989).

These two statements assert the importance and desirability of doctors participating directly in the management of the health service. However, they do not use evidence to substantiate this view, nor explore the possible dilemmas associated with it. One underlying

problem relates to the use of clinical resources. Government thinking was that once doctors were more actively involved in management and thereby accountable and responsible for the use of resources, then clinical effectiveness i.e. the best use of clinical resources, is more likely to be achieved, but what of the dilemmas this involvement creates for doctors (see discussion later in this chapter)?

Medical Managers

The past 10 years have seen a gradual realisation by doctors themselves that:

"No matter how clever you are, you cannot hope to introduce a new service into a hospital, raise the quality of asthma care within a health centre, or reduce deaths from heart disease in a region without understanding something of the techniques of management."

(Smith, 1995, p1).

Sir Maurice Shock, former rector of Lincoln College, Oxford, speaking at a meeting of doctors' leaders in November 1994 stated that:

"You must participate directly in the management of the health service. There have been too few doctors prepared to move into management. Those who do it have to be good doctors. It is no good having those who have dropped out because their medicine was not up to the mark" (cited in Smith, 1995, p2).

It took further reforms of 1991, together with stringent financial controls, to persuade medical staff that, when linked to Griffiths General Management, these changes had the potential to engulf medical staff in the kind of diktat and control they had resisted all over the years. Medical staff were becoming acutely aware that they must now involve themselves more actively in the formal management process if they were not to be increasingly managed by others. With this new found medical interest in management, emerged one possible resolution of the power-authority split which has been argued to characterise and impede effective management of the NHS. If they combined medical and managerial expertise, could doctors become, as Griffiths had suggested, "the natural managers" (Griffiths, 1983, pp18-19)? Part of my research was designed to test this idea, to try and see if this is so or whether there is any other way of achieving this blend to effectively manage the organisation at operational level, and to maximise the effective use of clinical and other resources.

Doctors in management in the 1990s

There are a number of ways in which doctors have become more formally involved in management since the Reforms. For example, approval for applications to become a Trust were subject to demonstrating the

involvement of doctors in management, whilst the post-1991, "Working for Patients" NHS saw the creation in secondary care of the statutory position of Medical Director. Although this was not initially one of the statutory positions for board members on Trust boards, the British Medical Association regarded this non inclusion as "a case of losing influence" (Marnoch, 1996, p50) and sought to have the legislation changed. They were successful, demonstrating once again the power of the medical profession to look after the medical interest and maintain its dominant position. They "won" that "skirmish" even if they "lost" the "battle" in that their opposition to the Reforms was ignored.

The appointment of a Medical Director became a requirement for all NHS Trusts, thus establishing a key statutory position for medical staff in top management. There is a significant difference in this role as opposed to the former chairmen of the old medical advisory committees who were elected by their consultant colleagues to act as "eyes and ears, spokesman, and occasional arbiter" (Marnoch, 1996, p49), to protect the medical interest. The new Medical Directors were not representatives of consultant medical staff, they had a corporate role, being part of the executive core of the Board running an NHS Trust and occupying that position in

their own right. Their role includes a statutory responsibility for providing medical advice to the Trust Board and a responsibility to lead Trust policies in the medical field (Marnoch, 1996, p50) together with a responsibility to contribute to decision making at Board level over the whole range of Trust activities. In the large Trusts, the title of Chief of Service is usually attached to the title of Medical Director to reflect the additional duties and responsibilities incumbent in the position in these very large organisations.

The involvement of senior medical staff in the NHS Executive, in Public Health and on Health Authorities are also important managerial positions in which doctors can and do influence and shape health services. In addition, so far as secondary care is concerned, an important and popular option for doctors to be involved in management is in the Clinical Directorate systems which have been set up in many parts of the NHS.

Clinical Directorates

Senior doctors have become involved in the formal management process at hospital level with the implementation of clinically based hospital management structures or, as they have become known, Clinical Directorates. This type of structure has its origins in

the United States and is sometimes referred to as "The John Hopkins Model." Whilst it was used as long ago as 1984 as an experiment in Guy's Hospital, London, in an attempt to avert a financial crisis in the hospital at that time, its widespread introduction into the National Health Service is relatively new. This will be looked at in some detail, concentrating on the secondary acute sector, as an example of some of the features and issues that arise when involving doctors in management.

In this structure a number of clinical specialties are identified, often grouping together specialties which have some commonality. For example, Obstetrics, Gynaecology and Paediatrics may well be grouped together to form one "Clinical Directorate." The essence, however, in the clinical directorate model is not only the fact of involvement of senior doctors, usually members of consultant medical staff, in the formal management process, but also in the way they are being involved. Clinical Directors are corporate managers in their own right and not merely representatives of a peer group.

In the main, it will be a senior doctor who will head the directorate in the capacity of Clinical Director. Usually, but not always, he/she will be directly responsible to the Chief Executive. In community units

however, primarily because there are fewer doctors in these units, the clinical director may be a clinical professional other than a doctor, such as a senior nurse, physiotherapist, pharmacist etc. He/She continues to undertake part time clinical work, but for the remainder of the time formally manages the clinical directorate, assisted by a small management team which usually includes a director of nursing and an administrator or business manager. This team, with its own budget, is accountable for its share of central costs as well as the cost of staff and service provision within the directorate (Harrison et al, 1994, pp89-90).

The major presumption in this type of structure is that by pinpointing the budget and placing the accountability thereof in the hands of the clinical director, the main spenders (medical staff) would seek to control the costs of their respective directorate. For example they may look more favourably on reducing the volume of in patient stay in favour of cheaper alternatives of outpatient consultations, diagnosis and treatment, once they were fully aware of the implications of the two alternatives and able to shift resources from one to the other.

Two leading early proponents of clinical directorates, Smith and Chantler, put it this way:-

"To reconcile clinical freedom with managerial authority and accountability...the consultants agreed to accept a system that sought to equate power with responsibility. In return for the freedom to manage their own affairs, they had to accept responsibility for the financial consequences."

(Smith and Chantler, 1987, p14).

Appendix VII shows a typical clinical directorate structure (in a pre-NHS Trust structure) in which it can be seen that the movement of accountability in this model is always upward, in sharp contrast to the traditional hospital organisation structure shown in Appendix VI.

The position of the clinical director in this type of structure clearly formally involves senior medical staff in management. In the words of Packwood et al:-

"In addition to being able to "hunt with service providers", the clinical director must also "run with the unit managers" and along with fellow directors and senior unit managers, contribute to determining unit plans and priorities as a member of the unit management board. This means acting as a corporate manager rather than as a representative of a particular directorate... It is deemed essential that clinical directors are acceptable to both the consultant medical staff and the the management board and/or its chairperson. This reflects the reality that they will be obliged to work in two modes; The political mode in leading their medical colleagues in the peer group, and the bureaucratic mode in managing the non-medical staff and contributing to unit management."

(Packwood et al, 1992, pp71-72).

This quotation from Packwood et al is a reflection of the merging of power and authority in one person. The corporate doctor manager has legitimate authority derived from the formal powers ascribed to Clinical Directors (in his/her job description) and the same doctor manager leads (and has the power to do so) the clinicians in line with overall Trust policy - but does so in a "political" rather than a "bureaucratic" mode.

Information systems

The significance of the development of information systems for NHS management was discussed in chapters 2 and 3. I return to this topic here because in the clinical directorate system, information and how to use it becomes centrally important for the doctor manager in relation to power and authority. The development of more and more ways of discovering and comparing what doctors do, using techniques and language which are not just those of medicine, is one of the most substantial threats to the power/autonomy of doctors. Though the medical profession has fairly successfully kept control over clinical audit, there are other information creating initiatives, not least those associated with evidence based medicine. These initiatives could be a major incentive for doctors to get involved in management-so that they keep themselves in a

powerful position to interpret and utilise the information for their lay colleagues.

The tools for managing clinical practice are developing, in some cases slowly (audit), but in other respects an information explosion is taking place which the doctor manager will have to appreciate and understand. He/She will need to place much greater emphasis on patient care systems some of which can be extremely complex. Computers, which in the past have been mainly used for administrative purposes, will increasingly be seen as essential tools for doctor managers as an aid to decision making and patient care management. In the NHS, in 1992 the Information Management Group (IMG) which had been established to bring together the various groups dealing with information, launched the NHS Information Management and Technology Strategy (Sutherst and Glascott, 1994, p57). The objective of this strategy was to bring together the various sources of information on patients to achieve a patient record that would be accessible (with controlled access to protect confidentiality) whenever a patient is treated and to build on to that record an entire clinical information system. Central to this information was the ability to communicate information throughout the NHS, with ultimately every citizen having a unique NHS number. Although the development of the so

called "Read" codes (the standard language of clinical terms used in health care throughout the NHS) resulted in much controversy, (which it is not the purpose to discuss here) a new development of these codes was expected to be announced in 1998 so that the codes could be applied automatically by the computer software running clinical information systems (Sutherst and Glascott, 1994, p57-58).

These are important developments for doctor managers since they will open the door to information about clinical performance never available before. If the information is used constructively and intelligently by doctor managers, it can provide them with the tools to promote more effective and efficient clinical performance, thus enhancing their power and authority position. If it is not, this can provide further opportunities for politicians and lay-managers to move into the territory of control over clinical decisions.

Appointment of a Clinical Director

The appointment systems for a Clinical Director vary between different organisations. However, these appointments are always temporary and are always part time. These are extremely important characteristics in the comparison with the lay managers' position. The temporary nature of the Clinical Director appointment

contrasts with the other more traditional scenario, where consultants tended to stay at one hospital once appointed, whereas lay managers would be more likely to "move on". It could be argued that medical consultants have more permanence than the lay managers, but the lay managers have more permanence than medical staff as managers. This is because the temporary and part-time nature of the Clinical Director's appointment can make the position "fragile" with implications for the balance of power.

There are a number of other common features to the selection of a candidate for the Clinical Director role, which, according to Sutherst and Glascott (themselves actively involved in a Clinical Directorate, Sutherst as a Consultant Obstetrician and Gynaecologist and Clinical Director and Glascott a business manager in a Clinical Directorate), writing for doctors who want to be involved in management, are:-

- i) The candidate must be acceptable to the majority of his/her clinical colleagues.
- ii) After a period of discussion and deliberation between senior doctors of the specialty, the Consultants will nominate one of their group.
- iii) The representative so nominated and elected by his specialty colleagues should also have the support of the Central Management Team.
- iv) The duration of tenure of the Clinical Director post should be agreed e.g. 4 sessions per week for a 3 year renewable

period (The remaining sessions will continue to be performed in the clinical field).

(Sutherst, Glascott, 1994, pp28-29)

Duties of a Clinical Director

In some Trusts, the duties of the Clinical Director are specified in fairly detailed job descriptions, whilst in others a much less rigid system will operate. The detailed job description can have advantages, however since the duties to be undertaken will very much depend upon the style of the person undertaking this role, such a rigid job description can have the disadvantage of stifling innovation and flexibility. A Clinical Director can either be a "Lead Doctor", in the clinical sense, or a mini Chief Executive depending on the style of the incumbent and of the organisation (Sutherst and Glascott, 1994, p29). The loose and flexible nature of some Clinical Director job specifications are very interesting, since most managerial job descriptions have fairly clear specifications which the individual is expected to fit into, not vice versa. However, in the opinion of Sutherst and Glascott, in either case there are a number of clear management rules which should apply:

- i) The respective roles of the Trust Chairperson, The Trust Board, The Chief Executive, The Medical Director, The Clinical Director, and Consultant colleagues should be clearly defined and understood by all.

- ii) The devolvement of budgetary responsibility should be real and allow the Clinical Director to have effective control over the use of resources.
- iii) The delegation of decision making powers should similarly be real. The extent of the devolved authority should be clear and unambiguous.
- iv) There should be clear collaboration and understanding between The Chief Executive and the Clinical Director.

(Sutherst, Glascott, 1994, p29).

The "bottom up" method of selecting a candidate for these managerial positions is a recognition that the support of consultant colleagues is an essential element in these appointments. The part-time, temporary nature of the position has both advantages and disadvantages. On the one hand it allows the medical profession to nominate a different candidate when the term of appointment has been completed if the doctor appointed does not match up to its (the medical professions') expectations, whilst affording the profession the opportunity to recommend an extension of appointment for another term if the post holder is making a success of the job from a medical view point. It also gives the Chief Executive/Trust Board an opportunity to limit the appointment of a Clinical Director with whom they are not happy. The disadvantage is that each new appointment to a Clinical Director position will, by definition, undergo a learning period during which time his/her capacity for

managerial decision making will be limited. Will this system of appointment challenge the "upward accountability" Packwood describes? (Packwood, 1992, pp71-72).

So far as the actual activities of the Clinical Director are concerned, he/she will be responsible for a very wide range of functions. An example of the range of agenda items for a typical directorate meeting (see chapter 9, pp375-376) gives some indication of the breadth of involvement. He/She will be ultimately responsible for the budget and overall performance of the directorate. This will entail leadership and motivation skills as well as building up key relationships with other professionals, both clinical and non clinical, inside and outside the specialty. Indeed, in many instances relationships outside the organisation will be extremely important, such as relationships with General Medical Practitioners (especially those who are fund holders or, now, influential members of Primary Care Groups), with Health Authority key personnel, with community health services, with other primary care professionals, Social Service Departments, and Community Health Councils, to name but a few.

Examples of specimen job descriptions for Medical Directors and for Clinical Directors obtained during my fieldwork research are included in Appendix VIII and Appendix IX respectively. The job descriptions for Medical Directors clearly demonstrate the responsibility for developing the comprehensive provision of medical services and advising the Trust Board on how these contribute to the aims and priorities of the Trust. Key areas of responsibility are to ensure that the general performance of medical services in all specialties is efficient and in line with current medical practice as well as the responsibility to develop and facilitate the participation of consultants in management. This latter point being important in the "succession" debate of doctors in management to be discussed later in this thesis (see chapter 9, pp354-358). The overall strategic leadership style required to fulfill the duties of a Medical Director are evident in the Medical Director job descriptions, "to create and maintain a team of clinicians providing the highest standards of clinical care achievable within the resources available." The specimen job descriptions for Clinical Directors (Appendix IX) emphasise more the operational requirements of the directorate and place emphasis on the need to develop, in conjunction with other consultant medical staff, a comprehensive range of effective services for the optimum

benefit of patient care and treatment outcome. The clear difference in the two roles being the direct accountability of the Medical Director to the Trust Board to develop the comprehensive provision of medical services and advise the Trust Board accordingly, whilst in the case of the Clinical Director, more emphasis is placed on operational matters within the directorate and on line management accountability to (usually) the Chief Executive.

In all clinical directorates there is a Directorate Management Team. Its composition varies but would normally include the Clinical Director, Business Manager, and Clinical Nurse Manager. This team would meet regularly to identify operational issues and deal with some of the day to day crises. It would also act as an agenda committee for the monthly Directorate meeting. In many clinical directorates, the posts of Business Manager and Nurse Manager have become one. This reflects the importance of the business approach which all directorates had to recognise in the aftermath of the 1991 Reforms in their quest to secure contracts from fundholders and Health Authority purchasers.

Scott and his colleagues discuss the involvement of clinical staff in the management of NHS Trusts and focus

on aspects which they considered critical to the involvement of clinical staff in management. These include:

"The decentralisation of management of clinical services so that responsibility for decision making on the use of clinical resources lies as close as possible to the point of delivery of patient care and a flexible approach to management arrangements which should adapt over time to meet the specific and current needs of the organisation, its staff and its patients."

(Scott et al, 1996, p11).

Scott et al advocate "Management by multidisciplinary team and of the need to develop shared views of clinical services between those clinical professionals who provide services and those with a clinical background who are commissioning them" (Scott et al, 1996, p11). Their comments recognise that the lay Chief Executive is not in a position to dictate the use of clinical resources. The comments once again highlight the difficulties regarding the split between the authority of the lay Chief Executive and the power of clinicians. As long as the split exists, control over the use of clinical resources remains fragmented and ineffective.

In the "new" National Health Service, in which contracts (or now, "service agreements") are one of the cornerstones of survival for Trusts, it is essential that

clinical directors are heavily involved in the contracting process (an area I pursued in my fieldwork research-see chapter 9, pp351-352), to ensure that "In an attempt to win contracts, managers do not offer more than clinicians can, or want, to achieve" (Roberts, 1993). The drawing up of the business plan, which is usually produced at Directorate and at Trust level, is one of the key ways in which the clinical director can make his/her mark in the formal management process. The business plan is now a mandatory part of the management of hospitals and directorates (Riordan and Simpson, 1995, p25).

There remains however the question of political considerations in leading medical colleagues in the peer group (Packwood et al, 1992, pp71-72). This is an extremely difficult area in which the medical director and clinical director have to operate. Difficult decisions often have to be made which make the doctor-manager less than popular with his or her colleagues (Riordan and Simpson, 1995, p25). The curtailment of some clinical activity, the encroachment into some areas of clinical autonomy, the questioning of some clinical practices, are difficult territories, but for the medical and clinical director these are areas of great importance in which he/she must be involved in order to successfully manage the directorate or contribute to the Trust Board. Since it is

highly unlikely that a medical director or clinical director would be appointed by the Trust Non Executive Members, advised by the Chief Executive, without the support of the Central Management Team and a majority of consultant colleagues (Sutherst, Glascott, 1994, p28), it follows that he/she has at least more chance of successfully tackling these areas than does the lay manager. This is because the power the doctor-managers derive from their medical background compared with lay managers is then linked to the formal authority they acquire on being appointed to these managerial positions. The complexities of hospital infrastructures and the demands imposed by the NHS reforms require highly developed management skills and appropriate management style, on the part of managers and doctors (Simpson, 1995, p18).

The Experiences of Doctor Managers

In 1995, Lyall published the results of research relating to the experiences of 5 doctors who had become involved in formal management, either as clinical directors, assistant chief executives, or in one case, a doctor who has become a Chief Executive of a Hospital Trust (Lyall, 1995, pp24-26).

Lyall's study showed that, in the opinion of the

doctors in the sample, being a clinical director had been one of the hardest things they had had to do professionally, with a great deal of responsibility for which they felt inadequately trained. Tensions with colleagues were identified whilst occupying management positions which evaporated as soon as they ceased to be in management, suggesting that one of the problems for the doctor manager is how to retain the support and cooperation of consultant colleagues whilst occupying a managerial role. One doctor in Lyall's sample felt that medical training should include training in stress and time management and that the structure and organisation of the NHS should also be included in the training. However, this doctor also felt that in his managerial role he was able to give staff a feeling of being valued and he had no doubt that the role afforded him the chance to effect change and alter the culture of the organisation.

Lyall's study included one of the few doctors who had become a Chief Executive of a Trust. He felt that doctors must be involved in management, including involvement in decisions about strategy, planning etc. The attractions of the managerial job for him were that he was able to make clear and important decisions, to see buildings and services come to fruition, in other words to make things happen. Another of Lyall's respondents

highlighted the fact that being able to effect change was an important aspect of the role for her. This doctor, a consultant anaesthetist, felt that being managerially in charge of day-care services had allowed her to make changes which, amongst other things, had increased the day surgery rates from 15% to 67%. This had also had a good spin-off effect, in that previously there had been a lack of applications for junior medical staff positions, whereas now they were over subscribed. Her involvement in management had allowed her to make these junior medical posts more attractive to applicants.

A female doctor who had become an Assistant Chief Executive after completing the GP vocational training scheme, suggested that when she first went into management she was regarded as a "traitor" by her medical colleagues. At first she found it difficult to be part of a managerial team and being expected to ask for advice, as her clinical training had focused on the individual face to face consultation and autonomous decision making. She felt that in medicine, consulting people is regarded as a sign of weakness, but in management it was part of the job (Lyll, 1995, pp24-26).

These observations by doctors involved in management serve to illustrate important aspects of the role of

doctors in management. It is clear from these observations that the main attractions for doctors who are, or intend to be, actively involved in management is that he/she can be instrumental in making things happen and getting things done. The involvement in "real" decision making is a key component in the involvement of doctors in management.

These examples from doctors (albeit those who had a mainly positive view of managerial involvement) offer support to the idea that doctor managers can bring power and authority together in the NHS. The doctor manager automatically acquires this blend as soon as he/she becomes involved in management, provided he/she also remains in the clinical field. The power which he/she already has as a doctor is then supplemented by the authority which active formal involvement in management brings. This blend allows the doctor manager to be instrumental, as the above actual experiences suggest, in getting things done, in making things happen. The doctor manager could potentially use this new found power and authority to bring about changes leading to a more efficient use of clinical resources; a position, in the main, denied to those who are not in possession of medical as well as managerial credentials.

However, a possible disadvantage to this combination of power and authority is that it strengthens the hold which doctors have always had over the NHS. It thus may allow doctor managers to pursue the medical interest without taking account of other, equally legitimate non-medical interests. This is a point I explored in my research (see p397). For example, they could resist the move away from secondary care to primary care, especially if this is accompanied by a reduction in hospital beds, a policy decision which the government, taking a broader perspective considers is in the best interests of the population.

Implications, Dilemmas and Problems.

The implications of the more active formal involvement of doctors in management are many and varied. For the individual doctor it usually means a reduction in clinical sessions of about 2 or 3 sessions per week in order to carry out the managerial role, sessions which are not always "back filled." It could be argued with some justification that this is a waste of a scarce clinical resource or a reduction in resources for direct patient care. It becomes a question of balance, balancing the loss of 2 or 3 sessions per week of clinical input against the advantages of having the doctor at the hub of decision making, using his/her clinical knowledge

strategically to help shape the overall direction of services. This issue was one of the areas I discussed during the interviews for my fieldwork research (see chapter 9, pp362-367).

Dawson, Winstanley, Mole and Sherval also describe some of the problems associated with doctors' active involvement in management. These include conflicting and unmet demands on time, issues of succession when the doctor manager's term of office expires, managing independent, autonomous colleagues who have divergent views, ill-defined budgetary responsibilities, human resource management and developing the skills needed to act in the marketplace and so on (Dawson et al, 1994). Although the problems are apparent, the NHS, in the opinion of Hunter, is a remarkable, resilient and flexible institution, it displays impressive adaptive qualities that would be the envy of any organisation, public or private (Hunter, 1998, p36). It is these adaptive qualities which have allowed doctors to become actively involved in management and to overcome some of the problems described by Dawson et al which are associated with this involvement.

In addition to the problems identified by Dawson et al, a number of dilemmas face the doctor in management.

One doctor manager in Lyall's study spoke of being regarded as a "traitor" by her colleagues when she first became involved in management, so the question of professional relationships, not only with medical colleagues but with other health professionals, is a real dilemma for doctors in management. Another dilemma is that doctors and managers are likely to have conflicting objectives. On the one hand, doctors have the traditional role as the professional dealing on a one-to-one basis with individual patients, whilst on the other hand the manager's role is to try and ensure value for money, to get the best out of scarce resources and look at the broad organisational picture. There is an inevitable clash of cultures in the two objectives. The manager's task to make the organisation more efficient and more effective often clashes with the strong medicalist view that the ethos of medicine is about giving the individual who is in front of the doctor the best treatment available, without consideration of the financial implications, or of others who could potentially benefit from treatment and care. Dilemmas such as rationing, clashes of values, allegiance to colleagues versus allegiance to the organisation and unpleasant managerial decisions affecting colleagues, including disciplinary matters, may have existed before, but they

become more focused when a formal management role is undertaken.

Traditionally, doctors have focused on the individual patient rather than the wider collectivity who may need medical treatment. Many doctors consider it wrong to have to overtly prioritise between one patient and another, forcing the doctor to exercise a clear rationing approach, as against taking individual clinical decisions. Some even contend that it compromises their Hippocratic oath. In practice, doctors have always adopted a type of rationing in their dealings with individual patients. However, these "rationing" decisions were often taken quietly, under the guise of individual clinical decisions, which in the past were seldom questioned. It is now widely accepted that demand will always outstrip resources. In the words of Harrison, Hunter and Pollitt, "There is a cogent school of thought that suggests that, because of the rapid advance of medical technology, the gap between what we could do and what we can actually afford to do is widening all the time. Thus painful choices concerning what to "leave out" are becoming more, not less, frequent" (Harrison et al, 1990, p139). The luxury of clinical decision making without reference to cost is rapidly disappearing.

Values of the doctor manager

Values can be defined as "An individual's criteria for judging the worth of things", and evaluation as the process of determining or attaching value (Stevens, 1976). Inevitably, the doctor who moves into a management position will be faced with decisions which conflict with his/her "value" position as a doctor. The doctor manager will have to take decisions on a population basis (apart from immediate life threatening issues), trying to ensure the best for the most, rather than the greatest for the least. These values operate and influence behaviour beyond the skills and knowledge which a person may have. It is therefore crucial that there is an understanding and appreciation of "values" both from a managerial and medical perspective, as well as the ability to cope with the inevitable conflict between them. This understanding and appreciation will be needed by doctors embarking on a formal management role in the National Health Service if they are to be effective, and by managers if they are to work successfully with doctors. The question of values therefore is another one of the dilemmas for doctors in management. Whilst it does not mean that the doctor manager has to abandon his/her "values", it may well mean that these values have to be re-interpreted to encompass the many, rather than the few.

In a political context, the development of doctors into a "think management" mode has distinct advantages for the government in that it departs from the emphasis on values and on clinical autonomy which have little regard for financial consequences and which have dominated medical practice in the health service from its inception. The government recognise, both politically and economically, that it is good to have doctors "on board", at the heart of decision making, especially when rationing of services and other unpleasant decisions are on the agenda. It could be that schemes and changes backed by the medical professional will be more likely to gain public acceptance than if those decisions are fronted by "men in grey suits." Whilst the high esteem the general public has for doctors is being challenged, it is true to say that the general public still relies on the traditional values which they have long attributed to doctors. They trust that the doctor has the relevant expertise and will act in the patient's interest, that "doctor knows best." For politicians the involvement of doctors in management can be politically expedient in that it shifts responsibility for unpleasant decision making away from the centre. Politicians recognise that so far as rationing of services is concerned and having to discriminate between different categories of patients (eg the elderly, those dependent on expensive drugs, IVF

treatment etc), there are no votes in having to say "No." In the opinion of Ham, when things go well, ministers and civil servants take the credit, when the going gets tough they decentralise and devolve the blame and responsibility. This according to Ham, has been the pattern of successive governments over the past 50 years, and recent governments are no different in that regard (Ham, 1998).

For the medical profession, there is a realisation that they are being forced to take on a managerialist role whereby clinical standards, though remaining under the control of their autonomous professional bodies, increasingly will have to be reconciled with strict financial controls (Marnoch, 1996, p119). The profession, in the opinion of Marnoch, may well prefer, "To pay the price of becoming the implementors of finance-based controls in return for the right to maintain control of medical standards, education and socialization" (Marnoch, 1996, p119). This involvement also means that no longer will the medical profession be able to maintain its former "caretaker mentality" (Shortell, 1989, pp7-23) in which it was often oblivious to resource implications of clinical decisions. The involvement in management means a "Re-invention of the relationship between the

profession and the management process" (Marnoch, 1996, p119).

Marnoch interestingly suggests that the medical profession seem to have accepted that they may have to allow themselves to be subjected to a diminution of individual power and autonomy knowing that this is more than compensated for by their enhanced collective power. The medical profession as a whole may even be strengthened by this shift away from individual doctor power, another example of the remarkable ability of the medical profession to respond to changed circumstances in order to protect its interests. Collectively they now have Clinical Directors in key management roles and in primary care the enhanced position of GPs acting collectively on primary care groups ensures a lead position for doctors in helping to shape health services in their locality.

There is a school of thought which suggests that the NHS may have to confine itself to providing only the "core" services in future and treatments such as, for example, IVF may have to be paid for, in whole or in part. Whilst politicians continue with the rhetoric of the NHS continuing to provide a comprehensive service, in effect fuelling increased patient expectations, the reality of delivering the service, meeting increasing demand, and

rising costs with insufficient money coming into the system, deciding who gets what and when, could increasingly be the responsibility of the doctor manager. In the opinion of Ham, if politicians go on as they have done we will see more and more rationing, we will see the NHS menu increasingly reduced, but not by openly debated decisions, rather through the back door (Ham, 1998).

There are implications for other professional staff of doctors becoming managers. Whilst a high proportion of clinical professional staff (particularly nursing) already regard the consultant (who has overall responsibility for each individual patient) as being clinically in charge, nevertheless it means a considerable shift in who manages resources, not least considerable nursing resources. For the lay manager it means much more sharing of decisions, much more debate and dialogue with consultants, increased emphasis on creating better working relationships with doctors, each recognising their area of responsibility in a way that is conducive to the overall goals and objectives of the organisation.

Looking ahead

A survey in 1996 of some 702 doctors who were managing clinical services, highlighted that the first generation of clinical directors were now moving on,

creating a possible succession gap with 23% of clinical directors likely to retire in the next five years (Simpson and Scott, 1997, p25). A high percentage of those in clinical director positions (some 44%) stated that the option to return to purely clinical work appeared more attractive than pursuing a career in management. One reason is the enormous extra workload which involvement in management entails. The BAMB/Cranfield School of Management survey found that clinical directors spent almost double their contracted hours on management tasks. (Simpson and Scott, 1997, p25).

Simpson and Scott, relying on the results of the survey which was carried out by The British Association of Medical Managers in collaboration with the Cranfield School of Management, (Simpson and Scott, 1997, p25) found that whilst the involvement of doctors in management meant that clinical directors were taking on a more strategic role, this involvement in management was still "hugely vulnerable and tenuous" (Simpson and Scott, 1997, p25). This was primarily due to the considerable workload such involvement incurred which in turn aggravated the "succession problem." However, according to Simpson and Scott, "The enormous benefits clinical directors can bring to the management of Trusts will only be realised with

continuing effort by chairs, chief executives and Trust boards" (Simpson and Scott, 1997, p25).

Discussion

In this, and in previous chapters, I have traced the evolving role of NHS doctors in management, from the pre-Griffiths years of informal involvement, through the Resource Management Initiative, the 1983 Griffiths General Management era, the 1989 "Working for Patients" reforms, up to the present Medical Director posts and Clinical Directorate systems which have been adopted throughout the National Health Service.

As many of the first generation of Medical/Clinical Directors come to the end of their initial contract period in formal management, it was an interesting time to carry out my fieldwork research. I wanted to know first hand the opinions and experiences of these "pioneer" Medical/Clinical Directors and the extent of their involvement in management, as well as the views and opinions of other involved health professionals. Therefore a range of research questions would form the basis of my fieldwork research, to try and assess whether doctors are the "natural managers" of the NHS, and if so, the implications thereof.

Against this background, in the subsequent chapters I shall examine my central research questions. These, and their associated questions, are developed and addressed throughout the remainder of this thesis, with analysis and interpretation of the data gathered in response to these questions, from my key informants in the field.

CHAPTER SEVEN

THE PROFESSIONALS' VIEWS

As described in chapter one, part of the research for this thesis involved interviews with 28 individuals who held a variety of senior positions, clinical and managerial in the NHS and two university researchers in the health management field. In this chapter and in the following two, the responses of those interviewed will be described and discussed using the frame-work of a number of themes (see pp42-43). The first three themes: the implications of the reforms and reorganisations in the NHS for doctors and management, trends in clinical autonomy and trends in medical/clinical audit are discussed in this chapter.

MAJOR REORGANISATIONS AND REFORMS: implications for doctors and managers

In chapters two and three, the history and implications of the major reorganisations and reforms were discussed, in this chapter I shall examine the views and

opinions of informants regarding these changes.

In response to my question, "What in your opinion have been the major changes in NHS management since the 1970s?" one of my respondents, a NHS Executive Senior Official, considered that the structural changes in 1974 which involved the unification of the former tripartite health structure, uniting the former local authority health services with the then hospital services, were the most major of all the changes which have occurred in the development of NHS management, not least because of the enhanced position hospital consultants gained as a result of the abolition of the tripartite structure. However, all the other respondents identified more recent changes as having the major impact.

A number identified the Griffiths Report as an important watershed:

"The sea change came with the introduction of the 1983 Griffiths Report recommendations, which introduced General Management and with it the realisation that you had to take doctors into management. I had been saying for a long time, we are the people who actually spend the money, we are the people who can make or break the service. In the past, for example, if a senior surgeon shouted loudest and made enough noise outside the Chief Executive's door, he would get his new operating theatre, but of course the flip side of that is that the poor elderly care service, or the psychiatric service didn't get what it needed and it sinks. Therefore we had to move doctors into management to stop that sort

of thing happening, to stop the high profile services gaining at the expense of others. In order to get priorities agreed amongst all medical staff and managerial staff we needed to strike a balance. In a world of finite resources I might now have to tell a consultant colleague, look you did very well last year, you got your operating theatre or whatever, now it is the turn of someone else. I now have the power and the authority to do that."

(Consultant Physician (1) Chief of Service)

"The one that changed the health service culture the most was Griffiths and General Management. Contracting is just a mechanistic process which we happen to have at the moment, but Griffiths was a sea change, moving from a supportive administrative structure to a leading management structure. I think that was a very radical change although not appreciated by people and still not appreciated by many people. That was the major change. I think it is easy to mix up the political requirements for change that were part of the agenda when the changes were brought in against the efficiency ones which were separate. What the government wanted to do at that time was to move a lot of the criticism away from direct government involvement. It has been very successful in doing this. I would suspect that this is the main drive behind all the present changes. The resource issues are quite separate, I think they are a red herring. I think getting more doctors involved in management is part of the issue."

(Consultant Physician (3) Medical Director).

These informants discuss quite a complex argument. They talk about moving from a supportive administrative structure to a leading management structure following the Griffiths Report which introduced general management. This accords with earlier discussion on the evolving role

of doctors in management and the role of the pre-Griffiths manager who acted (indeed had to act) in this supportive way, with doctors, at that time, maintaining a powerful informal interest, but with no individual responsibility or accountability for management issues or indeed for the efficient use of clinical resources.

There is a clear assertion by one of these informants of a covert reason for government encouragement for doctors to be more actively involved in management. As demand increasingly outstrips resources, with inevitable rationing decisions and difficult choices to be made, governments want to distance themselves from these difficulties which are not vote winning situations from a politician's point of view. Marnoch may well be correct in his view that the medical profession, whilst recognising the covert reason for government encouragement of their involvement in management, may be prepared to pay the price of being implementors of finance based controls in return for the right to maintain control of medical standards, education and socialization (Marnoch, 1996, p119). Another interesting point in the quotation from the Chief of Service relates to the ability to achieve a fairer distribution of resources once informal power/influence is replaced by the decisions of the doctor-managers.

A Chief Executive explained:

"When I think back over the past ten years I think the changes which introduced District General Managers and Unit General Managers have been undersold. If someone has to make a tough decision then that will be made. I think that has had a far more reaching effect than most people would realise. I think most people are quite scathing and say well they've not made any real difference. I've now worked, even in those ten years, in a number of places. I think it's fairly constant there has been quite a change, especially with getting clinicians involved. When I think of my Medical Director and my 5 Clinical Directors, the commitment they give and the sorting out of problems is tremendous, including involvement in disciplinary matters affecting clinical staff. I think that has been quite a change. I know there was always an element of that going on before, I'm not saying it never did, but I think that is more common now and people understand they are part of the corporate organisation and that there is a need to pull together for that organisation.

(Chief Executive, 3)

The views of this Chief Executive show a significant shift in the way the Medical Director and Clinical Directors have become involved in difficult managerial areas as compared to the informal involvement of doctors in management prior to the clinical directorate system. The involvement in disciplinary matters affecting medical staff is fraught with difficulty for the doctor manager but this respondent considered that, in his Trust, they were prepared to carry out this part of their role, demonstrating the extent of their involvement in

management. The team approach mentioned also shows the willingness of these doctor managers to work together for the overall benefit of the organisation.

For other informants it was the "Working for Patients" Reforms which brought the biggest changes:

"The changes, which came in after the "Working for Patients" Reforms in 1989, those have been the single biggest set of changes, all the others, yes they have all added incrementally, but those ones in 1989, building on to the 1985/86 introduction of General Management, were the biggest changes. General Management didn't make that major a change, especially for consultant medical staff, it was still pretty much just incrementally building. The 1989/90 changes were fundamentally different, fundamentally different."

(Chief Executive, 5)

"The White Paper, "Working for Patients", which created the internal market was the biggest change. This allowed General Management to gain a foothold, which it had not done until then."

(Consultant Histologist, Clinical Director)

The majority of my informants considered that the Griffiths Report which introduced general management would not have been successful had it not been for the changes which followed with the introduction of the 1989 "Working for Patients" Reforms. It would appear that the introduction of general management provided the

foundations upon which the "Working for Patients" Reforms were built. Neither would have succeeded without the other.

A general medical practitioner, responding from a GP perspective, considered that:

"The internal market has had a greater impact than anything else on the health service. To actually impose an internal market on the NHS, not only meant that everything had to be costed out and everybody had to be cost conscious of what was happening,... and then to introduce it, certainly from the GPs' point of view, with very little training, no pilot studies, or anything, and then to put an increasing part of that into the hands of the GPs was an enormous step. A step which over six years has borne fruit in some places but most GPs have felt overburdened with it."

ME: "Do they feel that this impinges too much on their traditional GP role?"

"Yes, they haven't got the skills to do it, they haven't got the management skills, they haven't got the strategic skills, thinking ahead, they can think about what they want today and what they want tomorrow, but they cannot think how their purchasing strategy might influence an overall strategy. If you ask most GP fundholders what their overall purchasing strategy is, i.e. what their five year plan is, you would discover that GPs are poor strategic thinkers and to devolve funding to a practice level creates a huge variability in purchasing strategy which makes the NHS unstable."

(General Medical Practitioner)

These views by a GP are particularly significant given the enhanced position the government now attaches to

GPs. The newly developing primary care groups whose main function will be in the strategic planning and commissioning of locality health services, will, in the main, be led by GPs representing their various practices. The comments by my informant GP emphasises the shift in power within the medical profession with the enhanced role of GPs, but suggests a potential weakness at the helm of these new primary care groups.

The introduction of Clinical Directorate Systems were considered by a number of respondents to be extremely important changes, typified by this reply from a Clinical Director:

"The opportunities which allowed us to push ourselves forward, which the Clinical Directorate systems allow, were the biggest impact for me. They enabled us to get more actively involved, to take responsibility, which doctors are used to in the clinical sense, now it would also apply to managerial matters. No longer was the informal influence type of involvement good enough to shape the direction of services. We had always had an element of power, but we never had any formal authority over non clinical matters. Doctors needed the authority to take management decisions as well as clinical decisions. We had to get involved in the decision making machinery to ensure a better use of resources for our patients. These systems allowed us independence to decide things, not total independence, but a greater degree of independence to work within a framework. This is one major advantage we had from the reforms, so long as we worked within the framework laid down we could decide what we want, we could get things done. This can be compared to previous when you had a hierarchy which prevented us from doing things

which would have been advantageous to our patients. We had to deal with people who did not understand the clinical situation. The Clinical Directorate system overcomes this and as such has been a major change for the better."

(Consultant Paediatrician, Clinical Director)

The reply from this respondent recognises that the informal involvement of doctors in management was no longer powerful enough, they had to get involved formally to become part of the real decision making machinery. The problems caused by the power/authority split were also recognised by this respondent. The bringing together of these two elements allowed him to get things done and released him from having to adhere to decisions by people who did not understand the clinical situation.

The interviewees were asked whether they thought the Clinical Directorate System could offer a better way of tackling the resource allocation problems of the NHS:

"The Clinical Directorate system is certainly one of the ways. If you give clinicians the scope to do things and include accountability for what they do and how they perform, then this is a way forward. You make them more interested, provided you allow them to manage their own affairs without too much intervention in what they are trying to achieve. It allows us to work out what is best for our patients and I think is a good system. I prefer it to the old way. It allows discussion with management and allows clinical initiatives to develop. The clinical directorate system has certainly made it more attractive for doctors to become

involved in management in the formal sense with real decision making powers linked to responsibility and accountability."

(Consultant Paediatrician, Clinical Director)

This respondent placed emphasis on being "allowed" to manage. He was prepared to stand by his actions and accept the responsibility which goes with real decision making, but behind his views is the resistance doctors have always displayed towards control by lay management. The simple fact is that doctors do not wish to be managed by lay managers. Individual doctors seem to be much more prepared to accept aspects of control from the doctor manager. i.e. the Medical Director or the Clinical Director, who, they feel, are more in tune with their way of thinking. This is possibly one of the main strengths of the clinical directorate system in that it allows this to happen.

One of my academic respondents considered that the Resource Management Initiative, backed up by the 1991 Reforms was the main initiative which brought doctors into management and, as such, a major change:

"Whilst management budgeting had been a failure, the Resource Management Initiative (RMI) was the major change programme in the NHS and it was the RMI, certainly in the acute sector, which brought the doctors into management. This ran in parallel with the 1989 White Paper. The White Paper had a huge political momentum, which pulled Resource Management along in its wake. In the 1960s

doctors and management were so far apart that they hardly saw each other because there was no reason to get pulled together. If you look at where it started to get pulled together, it was places like Guys, who were under such huge financial pressure that suddenly they began to start talking to each other. It was this, these financial pressures, financial crises that created the need for the common agenda and understanding of the need for doctors to come into management and be part of the decision making process. I think there are important changes going on at this present time, as it were, under the surface, i.e. changes in doctors working hours, changes in the way doctors practice, new medical technological changes and so on, and an even deeper change which is society's relationship with doctors.

ME: "On that point, society's relationship with doctors, how do you think that is changing?"

"The huge respect for the medical professional is still there but it is changing. Now society wants to know more about their treatment and care, about how the medical profession controls its members, how doctors keep their knowledge up to date and so on. Patients want to be partners in their treatment, they want to question the doctors judgement to understand the risks and make those choices themselves. It is about a kind of maturity in the citizens, it is about people saying "no, we are a bit shrewder than we used to be." I talked recently to a doctor whose patient had recently researched his condition on the Internet and questioned the doctor on what he was doing, this is a huge step forward for patient and doctor relationships."

(Senior Fellow)

These comments are extremely interesting and point to the rise of consumerism and a change in the status of Alford's "repressed interest" group. (see chapter 4)

This "hidden domain" (the community) could possibly emerge as the interest group which forces the dominant medical and the challenging management interest groups to examine their respective positions, indeed the rise of consumerism has been one of the sources of challenge to medical power. The government have recognised this and encouraged the promotion of the consumer interest by initiatives which give primary care a lead role in the future shape of health services. My respondent, in talking about the "maturity of citizens" is referring to the implications of changes brought about by the rise in consumer power. It would seem that Alford's view of the community as being the "suppressed" interest group where changes have been "stultified" by the operation of the other interest groups referred to above is changing, with the community interest coming more to the fore with considerable implications for doctors and managers.

A senior research fellow considered that in her opinion:

"The big change now is with the problems associated with the changes in junior doctors hours of duty and in the training of junior doctors."

(Senior Research Fellow)

ME: "Regarding the training of junior doctors, do you think now that there is more encouragement for doctors to be actively involved in management, something will have to be built in to the medical training programme relating to management? Some doctors who

have become managers say that they have never had one hour of management training."

"I think one of the biggest problems is trying to squeeze all the medical knowledge that needs to be taught into the junior doctor training programme. This is the number one priority. I don't actually think having management training as part of the direct medical training is necessarily the best way of introducing doctors to management. I think it may be more important that people can actually meet up with a wider range of people, perhaps some people having been consultants for a while, perhaps several years, who are taking on Medical Director posts, will be able to give people the opportunities. I think external opportunities and internal encouragement is the answer and I think if these things get some recognition, that can help. I think personal development, as well as medical education, should be seen as an important element to continue getting your recognition and I think that is something which the Royal Colleges could have something to say about."

(Senior Research Fellow)

On the question of the training implications of the reorganisations and reforms a GP respondent considered that:

"For a start there is a huge difference in training between GPs and specialists. So you have to identify which type of doctor you are talking about. First of all GPs in their training, although they do more management than most other doctors, get no management training, none. I have not had one hour of management training, although I run the practice. I now advise the Authority on purchasing strategy and things. Now there is a fault in there somewhere."

(General Medical Practitioner)

Although they varied as to what they thought were the

most important, the majority opinion from my informants was that the major changes had made it more necessary for doctors to become actively involved in management. The changes had created an awareness in doctors that they had to get formally involved in management if they wanted to be part of the change process which was sweeping through the NHS. There was an acute awareness on the part of some of my clinician informants that they could no longer rely on the informal influence of senior consultant medical staff to protect medical interests in this rapidly changing scene. The only way they could do this and help shape the overall direction of the service was to be involved in management. The Clinical Directorate system, provided one organisational structure, or vehicle, for them to do so. By definition therefore, this system also afforded a means whereby power and authority could come together in the hands of the Medical Directors and Clinical Directors - although under the leadership of a (generally) lay Chief Executive.

The main implication of this involvement is that henceforth the doctor manager would not only be part of the management decision making process but was also responsible and accountable for the use of resources, not least of which was the use of clinical resources. The involvement also placed the doctor manager at the sharp

end of rationing decisions, the traditional high public standing of the doctor being used to "sell" unpleasant decisions.

There was a general feeling amongst informants that the rationing issue was an important aspect of the role of doctors in management. It was felt that the doctor manager will increasingly be faced with difficult decisions especially when rationing involves clinical treatment issues. A number of informants discussed the rationing issue in some detail. As discussed earlier some informants felt that this was one of the reasons for the government's desire to get doctors more involved in management. The feeling was one of suspicion that this intention was there, i.e. that doctors were better able to sell rationing to the public and therefore should be encouraged to participate in the management process. Some respondents saw a major change as being the shift from covert to overt forms of rationing, linked to the contracting process which stemmed from the Reforms.

One respondent went on to say she felt that the rationing issue was going to have a major impact on the role of doctors in management:

"The actual recognition, and being prepared to admit, that rationing is an issue, explicitly rather than implicitly. I think that is an issue which society will have to confront. I

think there will be different responses to certain aspects of rationing, I think society is going to have to address the rationing issue more and more as financial resources get tighter. The rationing debate I suspect will be one of the main dilemmas for doctors interested in becoming managers"

(Senior Research Fellow)

CLINICAL AUTONOMY - IS IT STILL INTACT?

The last decade has seen the concept of clinical autonomy coming under increasing attack. Since this is a most important area for the doctor in management (much of the doctor's power was, perhaps still is, derived from the exercise of clinical autonomy) I wanted to assess in my research whether or not respondents perceived that this concept remained intact, or whether it had been eroded by the major changes.

A number of informants felt that it was important to define what clinical freedom/clinical autonomy actually meant. As one respondent put it:

"I think it is probably becoming better defined now as to what does clinical autonomy mean and some of the myths about what it meant. I have never known any manager tell a doctor how he/she should treat a patient. I have never known anyone even have the arrogance to say, "I feel confident to tell the doctor that they should be doing this procedure rather than that procedure." But what some people have put down as clinical freedom, (you can see it in things like standardisation on hip prothesis etc), it is very often personal preference. I don't regard that as clinical freedom and people are now certainly prepared to challenge that and

say that is not clinical freedom. Telling you how long you should take on doing an operation may be interfering with clinical freedom of clinical practice, but saying that you think there is a perfectly legitimate product which delivers as good a quality as something they are using that is three times as expensive and is denying other patients the opportunity, I don't think that is challenging clinical freedom. I think years ago, telling a doctor to do anything that they hadn't decided to do was seen as being an attack on clinical freedom, I think people are a lot more realistic now, I think they are now less willing to bring it forward as a spurious defence than they were years ago."

(Chief Executive, 5)

"I think it was a very loose and nebulous term and I think under pressure we are coming to understand what we mean by it more. I think in the end there is autonomy at the individual practitioner level. A doctor with a patient at the point of delivery is completely free to prescribe or to commit the patient to any sort of therapy."

(Consultant Physician, Clinical Director)

All the informants I interviewed spoke of the uniqueness and importance of clinical autonomy in the management of the NHS. One Medical Director felt that clinical autonomy had not been eroded by the many changes in the NHS over the years, although in some senses, doctors had always been constrained.

"Much of the "new jargon" of evidence based medicine, medical audit, guidelines and protocols and all other new concepts were potential threats, but clinical freedom/clinical autonomy had survived all of these. Whether these new ideas become reality I would be very sceptical, but only in the sense that clinicians have always either overtly or otherwise worked within a rationing

system. There are limited resources which some would say presents a threat to clinical freedom, in the sense that limited resources restrict what the doctor can do, but there have always been limited resources. Although clinicians may not have recognised that they were being constrained in what they did, in fact they were. In that sense, i.e. a restriction on the resources available to the clinician to exercise his/her clinical freedom, then there is a curtailment of clinical freedom, but that has always been the case, and yet clinical freedom is, by and large, intact."

(Consultant Physician (3) Medical Director)

This view accords with that of Marnoch who states that ways of managing clinical directorates are variable, "but with clear indications available that clinical autonomy is still largely intact" (Marnoch, 1996, p61). The question of clinical autonomy is a complex one with a wide range of views expressed by respondents as evidenced by these further interview extracts:

"The problem with clinical autonomy is that there have been some doctors who have seen that as an absolute right, irrespective of the resources available in the overall service, and that may be an intellectual position, but in the real world it doesn't work. So I think it is not so much that managers have sought to trample and to make clinical decisions, but by trying to find ways of working in a cash limited environment, they have forced doctors to go away and look at their practice and say, "Is there a way of doing this more effectively?" Clinical autonomy is a good thing, it is important, but it is not a good thing if it is simply hiding outmoded or shabby practice, and it can't just be used as an automatic defence to say no, no one can tell me to look at or review my practice or think about changing it because I

am a doctor, I don't think that is acceptable."

(Director of Purchasing)

"Doctors still guard clinical freedom/clinical autonomy jealously. I think people have had to become more accountable whether they like it or not. The consultants are about the only members of the NHS who have security of tenure and I think certainly we need to self regulate ourselves, if we don't do that then undoubtedly somebody else will do so. I think there has been a lot more emphasis in recent years on people keeping professionally up to date."

(Consultant Psychiatrist, Medical Director)

A number of respondents, felt that clinical freedom had been reduced:

"One of the big hurdles which is out there facing the NHS (and we are only at the tip of the iceberg at the moment) is litigation. There are increasing tendencies, if something goes wrong, let's sue for it. You even have situations where you have solicitors advertising in hospital waiting areas, for example, "Got a complaint about the NHS, come to us and we will try to get you some compensation." Now I'm not saying that you can have people operating and doing things, without some kind of redress for patients but I do think, and I find this from more and more consultants I have talked to, they are very, very worried about litigation. So much so, that there are some things they are not prepared to take on. I think consultants have got to be much much more able to defend themselves. So I think that takes a lot of autonomy away. I hope it doesn't totally and utterly stop people from being innovative and actually trying out new ideas, but I do think they have lost a lot of autonomy because you will get people doing things only according to protocols."

(Senior Research Fellow)

"I think clinical autonomy in the past has been something that consultants have valued, but in fact it is only an apparent autonomy. You are very limited really as to what you can or should be doing. The patients and the purchasers have more power now."

(Clinical Director)

Other informants expressed similar views: "You only have clinical autonomy if you have the resources to exercise it", and "Yes clinical autonomy has reduced, there has been a marked growth in managerialism which has contributed to this, plus limited resources and general management."

However, the view from the majority of informants was that consultant staff, by and large, are still able to do what they want to do, and that is what clinical autonomy means. Further views were expressed:

"Clearly every so often there is a bit of a fight to get the equipment you want or whatever, or a delay, but by and large, nobody tells the consultant what he/she should be doing."

(Retired Consultant)

"Clinical freedom/clinical autonomy are still around. But I think there are more consultants prepared to challenge each other about clinical autonomy with things like clinical audit and clinical effectiveness."

(Chief Executive, 4)

"Over the years, yes clinical autonomy has changed. The reason being is that what happened to start with, in the early 1980s there was total freedom in prescribing, there

was total freedom in referral, or whatever, what then happened, was an efficiency drive. In the need for an efficiency drive the market system was introduced. This meant that GPs were obviously then responsible for certain funds, prescribing funds, referral funds and methods, so that made GPs look at these funds and methods to find more efficient ways of doing it, so that made us look at our practices a lot more closely which was a good thing, that is not the problem I don't mind that. When you actually get to the point, and we are about at that point now, when you have introduced quality, have introduced protocols, when you reach the point where the pool of money that you are using has reached its limit, then GPs lose their autonomy and lose their clinical freedom, because that is when we have to "ration" and say to patients, no you can't have that but you can have that."

(General Medical Practitioner)

ME: "So do you think the curb on clinical freedom and clinical autonomy, is not so much what management does to chip away at this in trying to have more say in what doctors can do, but more the financial implications?"

"Yes. Our prescribing budget cannot meet the rising costs. Even though we have targeted drugs, we have done all sorts of things with prescribing, we cannot keep up with the cost increases. We had a £40,000 increase in our budget this year and we made savings on our budget last year, but already our forecast for the end of this year is an overspend. You only need one new drug to come along and it spends it."

(General Medical Practitioner)

"On balance, clinical autonomy/clinical freedom have reduced in importance, I'm not sure that's a bad thing. It gets back to accountability and I think it gets back to clinical effectiveness. We spend a lot of money sometimes doing things which are hard to justify and to argue that I am a doctor, therefore I do what I like, I don't think this is acceptable."

(Consultant Physician (2) Medical Director)

"I think clinical freedom/clinical autonomy have diminished, but I think it is right that they have diminished. I think we were not accountable enough. I think people were too autonomous. I think consultants were able, on a whim if you like, to introduce a new technique. A good example was key hole surgery, where there is quite a lot of argument as to whether there has been the right sort of development. People are challenging that now. Now there must be accountability, there must be training, we have to look at the results, at the outcomes etc. Now the clinical director can stop this and say, "Look you must be properly trained before you embark on this technique, we must assess the results."

(Consultant Physician (1) Chief of Clinical Service)

"The younger generation of consultants don't tend to raise this clinical autonomy issue as much. I think they understand that actually some of it was a sham anyway, there was always the tough decisions to be made, they made them day in day out. Really, to a degree, it is the whole rationing issue that now commands more public concern and interest, I think clinical freedom/clinical autonomy are still there, but I think it is less so. I think it has been eroded by the government wishing to push more and more at the public and saying, well it is the doctors who are deciding"

(Chief Executive, 3)

Clearly a wide range of views exist on this topic, a range which is reflected in the literature. Some writers argue that clinical freedom/clinical autonomy are still largely intact (Marnoch, 1996, p61). My respondents however, considered that there a number of strands to clinical autonomy which need to be considered. With regard to one of the strands, the one which concerns the

individual doctor patient diagnosis and treatment relationship, a substantial majority of informants felt that this aspect of clinical freedom was still intact, and that it was highly desirable that it continued to be so. However, my research suggests that the other strands, which involve, for example, the commitment of clinical resources, have come under attack by financial constraints and to a lesser extent by managerialism. These attacks have weakened clinical freedom/clinical autonomy to the extent that these concepts are less often used by doctors in an attempt to get more resources for their specialty, and even when the concepts are used, they are used in a much more responsible and accountable way, resulting in a more mature use of the term.

The weakening therefore of this strand of clinical freedom/clinical autonomy has been brought about, not so much by managerial diktat from General Managers, whose role in fact has done little to diminish the concept of clinical freedom/clinical autonomy, nor as yet by clinical audit, evidence based medicine, or protocols, etc, but more by purchasers and Trust Boards seeking to implement government initiatives, seeking to implement purchasing strategies, seeking to keep within strict financial targets and limits imposed by government

directives and seeking to provide services to the wider patient population.

An important aspect of clinical autonomy which one of my respondents mentioned is self regulation (see chapter 7, p283). Self regulation, i.e. regulation by the medical profession of the medical profession, is under close scrutiny and is increasingly being questioned especially since the Bristol tragedy (see chapter 2, pp64-65). Undoubtedly changes will be introduced to open up this self regulation so that other organisations and individuals (including non clinicians) participate in investigations concerning clinical treatment issues, challenging the autonomy of the medical profession to regulate itself.

MEDICAL/CLINICAL AUDIT

Some of the major changes identified by my respondents, in particular the changes associated with the White Paper, "Working for Patients", place great emphasis on better audit arrangements, "To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited" (Department of Health, 1989). For this reason I asked my respondents what were their views

on audit, had audit had any impact, had it made any changes to clinical practice?

"Not yet, I think the millions spent on medical audit has produced very little so far. Medical audit has lacked direction. What we are trying to do here is link data on clinical effectiveness and medical risk management and use that to prime audit. You can reverse clinical autonomy by asking, can you justify what you are doing now in the light of the published experience from everywhere else? The clinical director may then have to pose the question, "Can you justify this clinical practice to me?" This can be very difficult for the clinical director to do in the light of clinical autonomy, since he has to retain the support of his clinical colleagues. You have to find a non threatening way to go. I'm sure clinical effectiveness is one of the ways to prime audit and the that's what the audit cycle is about. Performance, against standards, review your own performance, do you fall out of line and if you do why, review your practice. I'm sure that is how audit should be used, not this ad hoc way that people have dreamt up. I don't think audit to date has been effective, but I think it could be if used correctly. It can be a very useful educational tool but only if used correctly. If it is used to manipulate doctors it becomes suspect."

(Consultant Physician (2) Medical Director)

"No, not to the tune of however many millions of pounds have been put in, I don't think to that level. I think it has culturally broken down barriers in that professional decisions can now be questioned outside of court. Previously it was generally just in court that those decisions were questioned, now a lot of departments are actually having discussions about difficult cases as part of routine, but being able to prove that that is worth the millions of pounds that has been invested is quite difficult."

(Chief Executive, 4)

I asked a Senior Fellow "Do you think clinical audit has helped to change poor clinical practice?"

"I think the first step back from that vision is to say, "Well what is clinical audit about?" Clinical audit is about peer review, it is about the fact that you can make your individual decisions but you have to understand that your decisions are reviewable and auditable by your peers. So you have to be able to defend your decision and point to evidence on which you made your decision. For me audit is not only about benefits, it is about costs and so a good audit will say, "What did your clinical prescribing cost and what was the benefit?" If you are prescribing extremely expensive drugs for which there is very little proven benefit when you could have been using those resources on other patients, well is that defensible?"

(Senior Fellow)

I asked a Medical Director, "Do you think medical audit has made people keep up to date?"

"No I don't think so. There has been a number of initiatives recently like quality, audit, the latest one is clinical effectiveness. All these things do (I mean, this is a cynical view entirely) is to raise expectations, and then when the resources are not available to meet the expectations, people say "Well, why did we bother?" I think what has made us keep up to date more has been peer group pressure, to be seen by your consultant colleagues to be keeping abreast of new advances in medicine, technological changes etc."

(Consultant Psychiatrist, Medical Director)

A view from a Director of Purchasing was that:

"I think audit is at the very early steps. I don't think anyone would argue that across the

country, it has really got in and shaken out doctors, you know poorly performing doctors still exist, poorly performing managers exist, it is much harder to deal with the poorly performing doctor than it is a manager."

(Director of Purchasing)

A Chief Executive considered that:

"I think clinical audit has the potential to make clinical change, but it is a very slow process. Perhaps more important is that clinical audit has the potential to weaken the power of individual doctors in favour of the group of doctors serving on audit committees."

(Chief Executive, 6)

The conclusions from a study carried out by Kerrison et al (Kerrison et al, 1994, pp159-167) suggest that medical audit had been accepted by the medical profession, but only on its terms (see pp103-105). In other words medical audit was acceptable to doctors if used by the medical profession, for the medical profession, as an educational tool to improve clinical performance. It had not however, according to Kerrison et al (and my informants), been effective as a control tool for management to manipulate the use of clinical resources. Regardless of the rhetoric about medical audit being a successful management tool to change resource use, it had as yet, not achieved that goal. Management and doctors had not developed the essential element of mutual trust which is at the heart of the audit function. Doctors saw

the emphasis on process (e.g. lengths of hospital stay) and managerial conclusions based on financially driven audit techniques but little or no emphasis on outcomes and impact in terms of "cured patients" or the overall needs of patients and the quality of their care (Hunter, 1997a, p332). What the medical profession saw was an attack by management on their clinical freedom, albeit in the guise of medical audit. However, evidence seems to suggest that even if this was the intention, it has not happened. Whilst audit had the potential to reduce the autonomy of individual doctors in favour of the collectivity of doctors it had singularly failed to shift the balance of power between clinician and manager regardless of the considerable resources allocated by government for this purpose. Indeed the way management had placed the wrong emphasis on audit was likely, in the opinion of Hunter, "to promote obscurity than transparency" (Hunter, 1997a, p333).

In the next chapter I shall be analysing and assessing the interviews and discussions I had with informants relating to aspects of management. What did informants consider to be the key management tasks in the NHS, what personal characteristics are required of an NHS manager, and so on? The purpose behind these questions is to bring out similarities and differences between

various groupings of respondents which would assist in my overall assessment of whether or not it could be considered that doctors are "the natural managers of the NHS."

CHAPTER EIGHT
KEY TASKS OF NHS MANAGEMENT - FROM BOTH SIDES

In this chapter, to explore whether there were any major differences in perception regarding the key tasks for NHS managers, and the importance of clinical knowledge between different groups of my respondents, I have grouped key informant responses into occupational categories and then divided them into (a) clinical and (b) non-clinical groups.

I wanted to know what doctor managers saw as the key tasks of NHS management and whether there was any difference between their perceptions as against the views of non-clinical managers. Was there any difference in emphasis and approach between the clinical and non-clinical groupings? I wanted to bring out not only differences, but also any similarities between these two groups, as well as the priorities respondents attached to the various tasks.

THE KEY MANAGEMENT TASKS

I asked my respondents: "What in your opinion, are the key tasks for NHS managers?"

Group (a) Clinicians

The informants in this group included a Chief of Service, an NHS Executive Senior Official, Medical Directors, Clinical Directors, General Medical Practitioners, a Director of Primary Care, Public Health Doctors, a Retired Consultant who was also an ex Health Authority Member, and other clinical health professionals.

A range of key tasks were identified by the four consultant medical staff interviewed who had become actively involved in management at Medical Director level. A unanimous view at a very general level was expressed, typified in this reply:

"Health care to patients, that's our main service, the reason why we are here."

(Consultant Physician (3) Medical Director)

However it was also apparent to them that there had to be cost effective management of resources and teams of professionals to achieve that aim.

"We need to plan what structures we need, what staffing levels of doctors, nurses and other staff will be required, what other resources we need to achieve our objectives."

(Consultant Physician (2) Medical Director)

The Medical Directors considered their role in management to be mainly advisory and strategic, their knowledge and experience guiding the strategic direction, pointing the way, "trying to get from here to there", trying to determine, in line with the corporate goals of the Trust Board, what is the business of the Trust and then, as part of the corporate role they share with other Board members, setting about making that happen.

"What is it as a Trust we are trying to do, are we trying to do everything medically or are we focussing on certain areas of medical practice? Having determined what the key business is going to be, over say the next 10 years, then how do we go about achieving that?"

(Consultant Physician (2) Medical Director)

It was also, they said, a harmonising role, optimising the use of resources, both human and financial, providing quality care for patients, cost effectiveness, good organisation, good teamwork. Paramount in their thinking, or at least in their declarations, was the delivery of high quality patient care within the resources available and with clinical involvement in all decisions and at all levels.

One of the Medical Directors considered a key task to be that of creating a new culture for staff, trying to provide an environment in which the full potential of staff could be realised. This Medical Director placed

great emphasis and a high priority on recognising the skills and experience of staff within his area of control. He regarded it an essential part of his job to ensure that the value and worth of staff is recognised.

"Staff should be encouraged to want to belong to the organisation and staff should regularly be told that the contribution each individual makes really does matter."

(Consultant Physician (3) Medical Director)

All the Medical Directors interviewed considered that there should be much more clinical involvement in contract arrangements than occurred at present. Clinicians should keep a careful eye on the market and how to market services with GP fundholders. They should develop an understanding with fundholders and try to work well with them, to have an idea what the people who are placing the contracts actually want and how services can best be provided in line with the wishes of the purchaser.

"A provider needs to be talking the same language as the purchaser."

(Consultant Physician (2) Medical Director)

The advent of fundholding meant a dramatic change in professional relationships between consultant medical staff and GPs. Behind the comments from these informants, is an indication of this changed relationship. Consultant medical staff quickly realised that fundholding

GPs now had to be taken much more seriously than before, there was a definite focusing of the mind taking place in favour of GPs, indicating a shift in the balance of power from the hospital consultant to the GP.

It was considered by all the Medical Directors interviewed that to retain clinical respectability they had to retain clinical responsibility. This presents a time management problem, nevertheless, they felt that if doctors in management move too far away from the clinical area then they lose medical credibility with their consultant colleagues. They will no longer be regarded as "one of them" and once they lose that credibility they lose it all and risk becoming failed Medical Directors.

This problem seems to be one of the main dilemmas for doctors in management. They must keep a foot in both camps, in the clinical and in the management, in order that they are not isolated from their clinical colleagues and the realities of clinical practice, yet at the same time are actively involved in the strategic and indeed, operational decision making of senior management. The workload associated with these two activities seems to be a critical factor in whether doctors continue to pursue an active interest in management. The literature talks about doctors involvement in management as being still

"hugely vulnerable and tenuous" (Simpson and Scott, 1997, p25). My fieldwork data would suggest that one important reason for this fragile involvement is because of the workload associated with the two activities.

The responses indicated an appreciation of the importance of the linking of management tasks, i.e. understanding the techniques of management, to plan, set objectives, control budgets etc (Stewart, 1989, p4), with the more subtle leadership skills of showing what he/she cares about (Stewart, 1989, p7) and understanding the organisation's "emotional and spiritual resources" (Stewart, 1989, p6). This showed that these informants had either adopted a most enlightened approach to staff management, or at least had grasped a progressive line in "management speak?"

As the above analysis suggests, there was considerable consistency in the views of these Medical Directors. Predictably the health care of patients featured as their highest declared priority, but their advisory and strategic role, their emphasis on good relations with purchasers, the high priority they accorded to the value of staff, the overcoming of workload and time management problems in order to retain clinical credibility whilst also undertaking managerial tasks, were

all considered key tasks by this clinical group. An equally important aspect of their perceived role was, in the opinion of one of the Medical Directors, to maintain their values as doctors:

"Patients trust doctors to do the best they can for them medically, doctors should always try to do this even when faced with financial imperatives."

(Consultant Physician (3) Medical Director)

A major problem for the doctor manager is this balancing of individual patient expectations against the interests of the wider collectivity of patients in a climate of enforced financial constraints.

Four Clinical Directors, who were all medical consultants, were interviewed. They identified a range of key tasks which included the provision and general improvement in services that patients require, setting priorities within their directorate, setting the direction, allocation of resources, communicating with the people they work with and explaining to them why particular courses of action are taken. Providing leadership, change management, deciding how things are done clinically, and how to maximise your resources; these were considered to be key tasks for Clinical Directors. They all felt that clinical knowledge and a clinical background were important to achieving these

tasks effectively. The application of knowledge, both clinical and non clinical, and developing the "art of the impossible" featured high in the list of key tasks for Clinical Directors in their management role.

The clinicians interviewed saw leadership as part of top management, of having a vision, setting the direction in line with the corporate objectives of the Trust, motivating staff and having the influence and control to bring about beneficial change.

One GP respondent considered that:

"Managers need to have clear vision, to be able to translate vision into action, to create policies and strategies, to analyse information, know where the information sources are and use the information to make effective decisions and to develop problem solving techniques."

(General Medical Practitioner)

Two informants considered that the reduction of trade union power in the NHS was an incentive for doctors to become involved in management. They stated that doctors saw long and protracted discussions with trade unions to be an unattractive proposition for them if they became involved in management. The reduction in these thus added to their interest in the management function. It was, however, also recognised that the Conservative

government policy in the early to mid-1990s of trying to install local pay rather than adherence to national Whitley Council pay arrangements could (in fact did) reintroduce the possibility of lengthy trade union negotiations.

Group (b) Non-clinicians

The respondents in this group included Chief Executives, Directors of Purchasing, a health service researcher, GP Practice Manager, Organisational and Development Manager, Locality Manager, the Chief Officer of a Community Health Council, and a senior fellow.

Providing and delivering services that patients need and then motivating staff to provide those services featured high in the responses of the six Chief Executives interviewed, none of whom were doctors. Identifying services that patients do not need was also an important feature. They all considered that the overall objectives of the Trust must constantly be at the forefront of their thinking, as well as facilitating the work of health professionals, managing the system, development of staff, promoting good communications especially with external bodies, leadership, quality standards, promoting patient choice. Adherence to government policy and working within financial constraints

were considered to be inextricably linked. Another view expressed was:

"We must remember that we need to make sure that systems work, that clinicians have the staff and equipment to carry out their clinical duties, that services for patients are in place and are of a good quality."

(Chief Executive, 6)

It is interesting to see that the "maintenance role" of the Chief Executive was featured on their list of priorities typified by this reply. Preparing and maintaining the environment in which doctors can carry out their clinical tasks was a hallmark of the pre-Griffiths manager (Harrison, Hunter, Marnoch, Pollitt, 1989b) (see pp204-220). It seems that even a decade after Griffiths this continues to be a major task for present day Chief Executives.

A similar view was expressed by a Senior Fellow:

"With general management so high on everyone's agenda, administration has become very undervalued, underrated and neglected nowadays. We must not lose sight of what really good administrators can do about making systems work, about keeping the service running, about delivering services to patients and so on."

(Senior Fellow)

Another view expressed by a Chief Executive was:

"Privatisation of support services and new legislation designed to curb the power of trade unions allows Chief Executives more time to concentrate on the delivery of patient services rather than spending inordinate

amounts of time on protracted discussions and negotiations with trade unions."

(Chief Executive, 5)

One Chief Executive considered that the management of change was an important and ever-increasing task. He considered that:

"The shift from hospital to community provision, reduced lengths of hospital stay, the introduction of new techniques, new technology, rationing, all were key tasks for managers as well as the political agenda, the internal market, the purchaser provider split, contracting arrangements, the Private Finance Initiative and the implications of this initiative."

(Chief Executive, 2)

Coping with change as a key task was reflected in the response of another Chief Executive:

"A fundamental change has been the changed relationships between hospital consultants and General Medical Practitioners with the advent of GP fundholding. This has been the spanner in the works. I think that has been one of the most dramatic changes that I have seen in my career, and which will have considerable implications for managers."

(Chief Executive, 3)

Leadership was considered by the majority of Chief Executives to be a key task for NHS managers. There were many different views of the current nature of leadership. One Chief Executive felt that leadership from the centre

was too autocratic, devolving responsibility only when things went wrong:

"The NHS is not managed at all, it is too prescriptive, it has too much direction from the centre with an artificial buffer to prevent blame and/or responsibility permeating through to the centre."

(Chief Executive, 1)

Another perspective, similar to that of clinicians, was that leadership could not be separated from good management, it was one of the inherent tasks of a good manager to lead. Some informants referred to leadership as "real" management which involved changes in behaviour, in feelings and in attitudes.

The local implementation of national policies was considered by one purchaser to be a key task. Purchasing managers needed to understand what the health needs are locally and to oversee, and try and shape services to respond to those needs. This required service planning, financial planning and change management skills.

One respondent, a Locality Manager, considered that information management was a key task for NHS managers. She said:

"Information management and being able to use that information accurately, particularly in community health services where our communication systems are generally worse. I

don't think anyone is dealing very well with clinical outcomes and outcome measures, proving what we are doing."

(Locality Manager)

Pursuing government policy was considered by some informants from a range of non clinical occupations to be the key task because of the National Health Service relationship to Parliament and tax funding. Improving the health of the population, trying to get other agencies to understand that poor housing, social deprivation, unemployment, poor life styles, smoking and poor diet all have a dramatic, and costly effect on primary and secondary health services were also emphasised. Health service needs assessment was a key task, i.e. bringing together the views of hospital doctors and GPs and then to work with doctors to try and link the delivery of health care with the needs assessment. To make the delivery of health care as efficient and effective as possible, linked with needs assessment, ranked high on the list of key tasks for NHS managers. A senior organisation and development manager considered that:

"Strategic planning, setting and implementing a strategic direction, balancing priorities from the centre of the NHS through local purchasers, GPs, local community, then things from within the Trust, Trust priorities, clinical developments, service developments, and pulling all these together in a strategic direction and within that the business plan which gives it all a definite focus. There is a need for financial management, bringing in income and managing the contracting process

as well as providing quality services that patients need."

(Senior organisation and development manager)

It was interesting to see that some of my key informants considered that, in addition to the delivery of health care, they must also bear in mind that they are, in many instances, the main employer in the local community and this should also feature in their considerations. They considered that they must also see themselves as part of the NHS and part of the wider social policy jigsaw. They recognised that purchasers and providers are in a public system largely funded by taxation, which is politically driven with initiatives like The Health of the Nation, Waiting List Initiatives etc. Therefore key tasks for NHS managers must take these political imperatives into account, these are part of the framework in which managers are required to operate. Not only do they have to make choices but also should be helping the local community to make choices, to listen to the voice of local consumer representatives and act upon their concerns, and indeed being a voice for the community in decision making forums.

Information management and being able to use the information accurately was considered another key task for managers. The underuse of evidence on clinical outcomes

and outcome measures was criticised by some, who in the main, considered that this was because of the constraints of time and the workload which prevented managers from making good use of this resource.

A number of informants considered that essential to all good management was good communication, not only about procedures and other matters within the hospital, but also within the community or within the practice so that professionals in different specialties and in different parts of the organisation know what other professionals are doing.

Comparing the views of clinicians and non-clinicians

Whilst there was some similarity in the key tasks identified by these groups the main difference seemed to be the greater emphasis the Chief Executives placed on the political aspects of their role. The implementation of government policy and the political importance of keeping to financial limits was much more evident in the responses from Chief Executives as against the Medical/Clinical Directors. The range of tasks specified was also different. The respondents in the clinical group were more focused on local internal patient services whilst the non clinical group of respondents seemed to identify a wider range of key tasks, some of which were external to

the organisation, i.e. relationships with external agencies, social policy issues such as poor housing, poor life styles etc, all of which have an impact on health and the delivery of health services.

The implication of these differences suggest that a balancing factor needs to be incorporated into structures which have doctors as managers, to enable a wider perspective on NHS organisation and management and on health issues to be taken. For example the White Paper, published in 1997, "The New NHS" (Department of Health, 1997a), will ensure that planning, commissioning and delivery of health and social care will alter as dramatically as it did in 1948, with new kinds of primary care organisations bringing GPs together, with representation from Health Authorities and Local Authorities in powerful commissioning groups. Although the doctor manager in secondary care is less likely to want to adopt these wider perspectives which extends beyond the NHS, as well as the ones which include keeping politicians happy, nevertheless such is the emphasis on the development of primary care services the doctor manager in secondary care will have to take these wider perspectives on board to accommodate these primary care changes.

PERSONAL CHARACTERISTICS REQUIRED OF AN NHS MANAGER

Group (a) Clinicians

A very wide range of personal characteristics was identified by clinicians as important for a manager in the NHS. Analytical skills, communication skills, high intellectual ability, change management skills, good inter-personal skills, and "people skills", were all considered important by informants, together with an aptitude for management and the ability to make difficult decisions.

It was considered important to be approachable and flexible, so that people can feel that they can come and talk if they have a problem, and then being prepared to talk to them and try and understand their problem. It was necessary to be respected and to have credibility, and this recognition had to be earned. For a clinician to be an effective manager, there is a need to be respected clinically. It was felt that it would be extremely difficult to manage a clinical directorate if there was no understanding of the clinical problems inherent in that directorate.

Whilst it was felt that top managers did not have to

"know everything about everything", one informant felt that:

"They need to know the context of the services of the NHS in which they work, to be leaders, to be enablers, to allow people to develop and trust them to do the things required. There needs to be complementary personal strengths amongst the team with whom you work, some people are better on ideas, some better at enthusing other people and getting people to do things, some will lead by example, essentially, to have a bit of all these things."

(Consultant Psychiatrist, Medical Director)

Integrity, courage, the ability to understand the politics of the situation and listening skills, were all considered to be important personal characteristics, with perhaps the last, the listening skills, all too often poorly developed.

Leadership was high on the list of required personal characteristics. It was considered by some to be one of the skills the Health Service didn't recognise as being as important as it should. In top management, leadership is considered to be part of the management process:

"If we are talking here about senior management in the Health Service in its various guises, then leadership is part of that management process. So when I consult staff here who are senior or middle management, some of them show leadership and that may be appropriate to some of their tasks, but it is not necessarily their main task. But for my job, leadership is very important and is an essential feature of my

task. I certainly regard my job as including being a professional leader within the authority and I hope that also extends to my professional peers outside. That is a very important part of my role to which I pay great attention."

(Director of Public Health)

It was considered important to be able to share a vision, to be able to articulate, to make coherence out of chaos, and try to bring various strands of activity together, also to be able to make things happen and create beneficial change.

Informants felt that there was a requirement to be able to articulate the way ahead and convince, persuade, communicate with staff and to encourage them to contribute. One informant said that,

"We should encourage staff and make them feel that they "belong" to the organisation and that their contribution is important."

(Consultant Physician (3) Medical Director)

It was felt that there must be flexibility in the system so that management isn't about telling people to the last tiny detail:

"A lot of things are done in the NHS by *allowing* professionals to be professionals."

(Consultant Physician (3) Medical Director)

Other personal characteristics identified by my key

informants stressed that a sound knowledge of the NHS, its functions, its qualities, its strengths and its weaknesses was essential. There was not much support for the (1980s) idea that the NHS needed to have good managers from outside the organisation, to take a fresh look.

To be able to communicate and bring other professionals, be they hospital doctors, GPs, or other health service professionals, together and be able to use their skills and try and utilise the available resources as effectively as possible were also seen as vital:

"The importance of having a team approach must be emphasised. The manager must have the confidence of the consultants, the GPs and the other health care professionals, he must be able to use their ideas to tap into what they are good at in order to do what he (the manager) is good at. To listen and ensure that you as a manager hear a variety of opinions about an issue and that you cover the range of stakeholders in any issue."

(General Medical Practitioner)

One informant in this clinical group considered that when Trust Boards are seeking to appoint doctor managers, the key is to appoint people who are team players and motivators, as well as people who have the required professional skills. At this level, he felt that what they are now looking for are people who have vision, who can communicate, who can work with other people, yet still be tenacious, who can motivate, as well as people

who have the requisite professional skills for the position. In his opinion, they are looking more now for the right personality, almost taking the other skills as given, once someone has their professional training and experience behind them. This focus on team players, on the right personality, on being able to work well with other people, these qualities, he considered, are increasingly important in NHS management.

The qualities which this informant identified could be suggested as the basic ingredients of the development of good management skills in future doctors in management. To be able to promote partnerships in decision making and to be able to motivate staff to give of their best to the organisation suggest that consultant appointment panels should now be placing much more emphasis on people management skills than in the past. In a labour intensive organisation like the NHS, this is of fundamental importance and suggests that successful candidates for "doctor in management" positions will now be very different individuals from the consultants who used to have the greatest informal power on the basis of their individual status and that of their specialty.

Group (b) Non-clinicians

Those interviewees from non-clinical backgrounds

considered influencing, negotiating, listening and facilitation, all to be essential personal characteristics of a good manager. Not all top managers were seen as possessing these characteristics. Some were particularly seen as bad at listening to what patients want and what the community wants. Credibility featured high as well as integrity which was considered to be extremely important in a public service.

"People management skills, the ability to handle staff and taking people along and making them feel that their contribution does matter would rank high in my list of personal characteristics, as well as the ability to optimise scarce financial resources."

(Chief Executive, 6)

Another respondent considered:

"A lot comes down to definitions of leadership and management. We have this debate with the doctors sometimes because they are usually comfortable with leadership, they don't have a problem with leadership, they say they do it all the time, but then you start talking to them about management and often it is what they have found as management is administration and bureaucracy. It is this element of management which is the thing they shy away from, but they like the leadership aspect in terms of having some influence and control over what their services are doing and how they are working. In my definition, all of that is part of management and all of that is part of leadership and you can have leaders at every part of the organisation. When it gets in to debate it is usually when people have different definitions of those two things really."

(Senior organisation and development manager)

Strategic and lateral thinking, with the latter said to be neglected amongst managers, were included. These skills as well as a range of inter-personal skills which facilitate the handling of very complex decision making processes in a publicly funded service that is always going to be short of money and which is never going to be able to meet all the expectations put upon it, ranked high in the list of personal characteristics.

"As a manager you need also to be able to involve, and in some cases lead, external agencies whose services have a bearing on your services. Health care isn't delivered by one agency or purchased by one agency, it is about local authorities, it is about primary care providers, it is about social services, it is a kind of network, a fabric within which you must operate. A manager has to be extremely political with a small "p" he must be sensitive to power and who holds power in a particular situation, to be able to understand that and being able to respond to it."

(Senior Fellow)

"Approachability has got to be the main one as far as I can see. Unless you are approachable then you are not going to find out what is happening on the ground. I think you have got to be innovative as well, you have got to be coming up with new ideas and new ways of doing things particularly with a bent on efficiency, doing things more efficiently."

(Locality Manager)

Another view was that a good knowledge of the service being managed and a consistent approach will command respect and encourage people to work better. It is

necessary to be seen to be firm but fair, to know what makes people tick, how they work, how they can be motivated so that they "want" to work for the organisation, how to encourage staff to work together as a team, these are all personal characteristics required of an NHS manager. It was evident from the fieldwork data that this combination of people management skills was seen by almost all respondents to be increasingly important. A mastery of these skills should be one of the goals of the NHS manager whether doctor manager or lay manager.

DOES IT MAKE ANY DIFFERENCE WHETHER MANAGERS ARE DOCTORS, OR LAY MANAGERS, OR OTHER HEALTH PROFESSIONALS? IS CLINICAL KNOWLEDGE AN ESSENTIAL INGREDIENT IN THE MANAGEMENT OF THE NHS?

Group (a) Clinicians

Whilst the majority of informants in this group felt that professional background did make a difference, they also considered that people from different backgrounds have different things to offer. A mix of skills was seen as advantageous at the top level of NHS management, as it contributes to a solid team approach and should have enough variation to cover "all the angles."

It was felt by all in this group that doctors should get actively involved in management:

"This does not have to mean total control, but they have to get involved somewhere, there must be medical input into decision making,

the health care clinical professionals are the ones who do the business."

(General Medical Practitioner)

"One of the motivations for those doctors to want to get involved in management is, they say, to prevent the service drifting away from them. That is one of the motivations, it is not the best, the best motivation is not to stop it drifting away but is to take a firm grasp of issues for positive, not negative reasons."

(Director of Public Health)

The important features highlighted by my informants are that clinical views must be allowed to be expressed, that they must be listened to, and acted upon. It was considered that in a role that has such important clinical features attached to it, if somebody is medically qualified or has a strong medical slant in their experience and training, then that ought to have a bearing. The view was that there was always difficulty when non medical management fails to listen to medical advice. However, respondents on the whole, felt that this failure to listen to the medical viewpoint only happens in some places. Very often the system works very well.

A view expressed by a Clinical Director related to the power and authority position of the Medical Director. This is a good example of the lack of control the lay Chief Executive has over consultant staff. Even specific

instructions from the lay Chief Executive can be ignored by consultants and any insistence by the Chief Executive to have his/her instructions adhered to, especially on a clinical matter, could well result in a vote of no confidence by consultant medical staff, thus placing the lay Chief Executive in a non tenable position:

"When the Medical Director "suggests" we do something, we do it. If the same suggestion (or even a formal instruction) came from the lay Chief Executive we may well question it, argue about it and in the end may not respond, especially if it was concerned with a clinical matter."

(Consultant Physician, Clinical Director)

One respondent said that he felt there was still a suspicion around between lay managers about whether doctors should "be fiddling in this" (i.e. participating in management). Another informant said, "If you want to take medical staff with you it is important that some doctors are managers. Clearly not *all* doctors need to be managers." Some doctors who have become involved in management feel that their main motivation in this respect is to be able to put things on course as they would see it as clinicians. It is essential, they said, to have the appropriate clinical professional managing the core functions of the clinical directorate.

Another informant, a senior medical consultant,

stated that in his structure, where he is Head of Clinical Service, he has a divisional manager and a deputy divisional manager, both of whom have a nurse training base. This he said creates a sound divisional structure. He sees the two backgrounds; his as a medical consultant, together with the nursing background of his divisional and deputy divisional manager, to be complementary. He considered it would be extremely difficult for a non-doctor manager to run a service involving about 30 medical consultants, many of whom have doctorates in addition to their medical qualifications. He felt that the manager has to be up there with them, to understand the level, including the clinical level, at which they operate.

A senior nurse manager felt that a clinical background was essential. In her view:

"The manager needs to know and understand the clinical responsibilities and pressures incumbent in a clinician's everyday tasks. The failure of non-clinicians to recognise these pressures results in poor management decisions."

(Senior Nurse Manager, 1)

The majority of informants considered clinical knowledge an essential ingredient in the management of the NHS. However, the level of clinical knowledge required by a manager depended on whether or not you had a properly

developed, representative advisory system. This group of informants, felt that it didn't so much matter which way you organised your advisory system, but it had to be good, had to have good representation and above all had to be listened to. This latter point was considered to be crucial:

"For example, take coronary heart disease. This disease is a national topic that has come down as government policy, it is one of The Health of the Nation priorities. Now to that extent lay managers need to know what coronary heart disease is about, they need to know what the procedures are and what they cost, what alternatives there are and what the clinicians are doing because they will find that certain clinicians follow a certain pattern and others follow another pattern. People without a clinical knowledge have difficulty knowing and understanding these matters. I know there is an attempt now to get protocols developed so that when a certain thing happens medically there is a sequence of events to treat that medical condition. There is no doubt there is a move afoot to try and rationalize the clinical outcome, the clinical result, the Evidence Based Medicine approach. The argument is that if you do the "proper" way properly you get better results, but medicine isn't like that. Non medical managers must take advice on clinical issues, must make sure it is properly constituted and reliable, they must know enough themselves to say that sounds right, that sounds wrong."

(Retired Consultant)

This informant, who was well experienced in the clinical field and in the senior management field, having been a Consultant for a considerable length of time and

having served for some years as a Management Team member, felt:

"The way management is being set up at the present time with the development of clinical directorate systems has a lot going for it. This is because in the Trust management you have a Medical Director who is there (among other things) to talk about clinical matters and clinical issues, this is a major part of his role, not merely representing the views of others, he is there because of his own clinical and medical knowledge and experience to advise the Trust Board on these clinical and medical matters. Then behind this you have the Clinical Directors, all the clinicians in their groups in the directorates, all feeding in. In addition to this are the business plans, the working plans, the purchasing plans, all funnelling in to the overall operational and strategic direction laid down by the Trust Board. This creation of a formal management structure in which doctors can operate is a considerable move forward from the old MAC/MEC system."

(Retired Consultant)

Some informants considered that the more senior you are in management, the more need there is to have clinical experience. At that level you get exposed to the management issues which have direct clinical implications and these managers are better able to understand the issues if they are clinicians. This will then be reflected in better decision making.

Some informants took a strong view that to be a good

NHS manager it is a considerable advantage to have clinical knowledge and clinical experience:

"These are basic requirements, you have a head start if you have been, or still are, a clinical professional. NHS management, regardless of the rhetoric that it is no different than management in industrial and commercial settings, is in fact very different. A clinical background, be it as a doctor, nurse or other clinical health professional provides the foundation upon which NHS management skills can be built."

(NHS Executive, Senior Official).

Whilst agreeing that clinical knowledge was essential, some informants in this group took the view that what staff looked for in a person of authority was competence and, for them, competence in the health service was actually understanding the business of the health service, a major part of which was clinical business. Understanding the clinical business of the health service was the single most frequently mentioned requirement for an NHS manager by the majority of informants in this group. The uniqueness of NHS management as compared to other large organisations was highlighted by this majority of respondents. These informants considered that for someone to come into the NHS at top management level and say "Well I haven't any experience of it, I don't understand it, but I can run it", was folly in the extreme. A view expressed was that, "The manager has to hit the place running" (Consultant Physician, Medical

Director), challenging the notion that there are generic management skills which can be transferred to the running of any organisation, regardless of its product.

It was felt that, up to a point, consultants will be sympathetic and supportive if non clinicians have made an effort to understand some of the technical issues which drive them, but if such non clinicians make no effort to understand the clinical service, they lose credibility. For example, if they mention a particular piece of medical equipment and the non clinician manager hasn't got the faintest idea what its function is, then credibility is immediately lost.

In relation to doctor managers, very much allied to this question of clinical knowledge within this category of informants, were the twin qualities of respect and credibility. It was felt that a good or poor reputation in the clinical field will transfer with the individual into the management field, and their clinical ability and the ability to "get things done" will have a bearing on their respect and credibility in the eyes of colleagues when they enter into management.

Informants in this group felt that the Trust Boards need good, clinically well experienced Medical Directors

sitting on the Board. One emphasised that there are people sitting on the Boards who are lay people, who will bring their own expertise, but this needs to be married to the clinical perspective which only the clinician can bring, to point out to the Board the clinical implications of what might appear to be good managerially, but which, with the best will in the world, lay people simply do not know or understand. There must, he said, be clinical input to make jointly sensible managerial decisions. This is not to say that those without clinical skills are less important, but there must be a mix.

Whilst the large majority of my informants in this group were referring to the clinical knowledge of doctors, a number of informants considered that this knowledge could also come from other health clinicians, in particular from nursing staff. Nurses, some of my informants considered, can be very good managers; after all the whole business is about delivering patient care, and nurses, who form the largest occupational group in any hospital, have direct first hand experience of this. The Ward Sisters are regarded as central to this care and one of the most important groups of staff in any hospital.

A Chief of Service considered that some people often

forget the main purpose of their professional existence:

"I often have to remind some of my colleagues on the management group that the only reason patients come to hospital or come into hospital is for nursing and medical care. They don't come for the food or to be wheeled around by porters, it is all to do with medical care and nursing care. The whole sub structure is to do with that. People tend to forget this."

(Consultant Physician (1) Chief of Service)

One informant, a Director of Public Health, drew the analogy with a senior manager in the Ford Motor Company. He stated that he didn't suppose the senior manager in Ford necessarily knew what a crank shaft is, nor would he need to, but he must understand why people want motor cars, what they want in them, what they want to use them for and so on. Therefore in the health service as a senior manager it is necessary to know why you need screening services, why you need acute services, the potential pitfalls of not having certain services properly organised. It is, he said, beneficial to have some understanding of the opportunities for development. For example, the field of new technological developments is a major problem area, with new developments and new drugs all the time, which may be very expensive, might be effective, might be poisonous. The doctor would not expect the non clinician manager to understand these dimensions, for example, how the drug gets into the body

systems, what receptors it latches on to, what clinical reaction it creates, and so on. However, they do need to understand issues like cost, effectiveness, danger, patient expectations and so on. The great danger, in his opinion, are people who believe that it is unnecessary to understand the business of the health service at all. This, in his view, had happened all too frequently.

It was the majority view of this clinical group that there is an advantage for the manager to be a doctor because change needs power and influence and the doctor manager is better placed to have this, especially with his/her consultant colleagues. A small minority in this group felt that staff in any of the health professionals ie doctors, nurses, lay managers, other clinical health care professionals, could be effective NHS managers. The small minority view was that the skills of the doctor are better utilised in the clinical field for which he/she is trained, rather than in management.

Group (b) Non clinicians

A Chief Executive spoke of the limited control he has over consultant medical staff:

I know there are things I would like to achieve, but there isn't any point in even thinking about it because I do not have the power to change clinical practice, but they could, and they get away with it because they have the clinical clout. People like Medical

Directors can get away with a lot more than Chief Executives in relation to clinical matters because there is almost an acceptance by the medical staff that if the Medical Director says this is what we have to do, they don't often give absolute diktats, but if they say that is what is going to happen, it will have to happen. But if it is the Chief Executive they will argue because you are trying to mess around with clinical issues, whereas people will accept it from a Medical Director."

(Chief Executive, 5)

The views of this Chief Executive accord with the views of a Clinical Director (see p319) and suggests a flaw in the management structure which purports to regard the Chief Executive as being in overall control. Clearly this is not the case so far as consultant medical staff are concerned.

Some respondents expressed concern about doctors as managers. One informant considered that:

"In many cases doctors are disasters when it comes to what is management, what is leadership. What they don't have is the vision, the wider perspective. The doctors experience outside of the face to face contact with patients is minimal, so they don't have what I call the perspective."

(Chief Executive, 1)

Others also expressed concerns based on the nature of doctors' training, as primarily focused on looking at individual cases, not at the wider perspective. It was

acknowledged that the general public will take a doctor's message rather than one from a "man (or woman) in a grey suit." However, they disputed the view that it is easier for a doctor manager to persuade their clinical colleagues to support them, so it is difficult for the doctor to manage an NHS organisation. It was considered that doctors do not find it easy to tell their colleagues what to do. Other informants felt that having trained someone to be a very experienced consultant to then want them to go into management was wasteful of their clinical skills. Some argued that it was more difficult for doctor managers to make harsh decisions than it is for managers from the other professions. "They have to face up to their doctor colleagues who almost expect non doctor managers to do "nasty" things, they don't expect doctor managers to do things like cut clinical services."

Other informants in this group felt that no one strand of the service should have a monopoly of management. They did not feel that doctors were "the natural managers", but accepted that some doctors were very good at management. It was not felt either that nurses are automatically the best managers, although they had produced some good managers. "Management" here is seen as involving a set of skills and abilities which are

associated with particular individuals, rather than with particular professions.

Another respondent considered:

"They can come from anywhere, I have no problem with that. I think educational or professional background doesn't matter too much, I think it helps, it is very useful if someone has some form of clinical professional background in terms of managing health, because they actually understand the language. I think a clinical manager has a head start because there is a whole area of knowledge which is very very useful, but we have examples of managers who come in from complete different areas of work and managing, but they just have a larger learning curve. It is harder for them to really understand the business they are managing, so yes I think it helps, but is not essential.

(Senior organisation and development manager)

The importance of the NHS culture was considered to be important by one respondent:

"To manage in the NHS, it is necessary to understand the NHS culture. If a doctor wants to become a manager then that is an option that should be open for him/her, just as it should be for any other clinical professional. A good mix of people in management, whether they be doctors, nurses, physiotherapists, lay managers, whatever, is good, they add to the team that you have managing the organisation and bring with them the different experiences which enrich the management team."

(Chief Executive, 2)

Without exception, informants in this group stressed that the non-clinical manager must have clinical advice readily available and must use that clinical advice in decision making. Specialist skills, medical, nursing, financial and so on, should be regarded as desirable supplementary skills, rather than being a requirement for management. A number of informants in this group recognised that lack of power over the management and control of consultant medical staff could well be a handicap for the non doctor manager in the efficient management of the organisation. To try and overcome this problem they felt that they had to build up credibility with consultant medical staff and work with them especially when discussing matters concerning the use of clinical resources. A substantial problem identified, without exception, by all my informants in this non clinical group was the difficulty which lay managers experienced when attempting to change inefficient clinical practice.

Another view expressed by one respondent was that everyone has particular slices of experience and knowledge. Managers, whether they are doctors or other health professionals, all need to learn about the other parts of the system they are working in. He recognised that doctors are often highly specialised so the extent of

their clinical knowledge beyond their specialty is quite limited. However, this informant considered that there are some really effective doctors in management:

"Doctors are by definition, relatively gifted people and they have talents to bear, some of them are odd, but nevertheless they are highly intelligent and gifted."

(Senior Fellow)

It was recognised that an in depth, overall knowledge of an organisation as vast as the NHS was not feasible. Nevertheless, this group recognised the importance of at least having a surface knowledge of how other parts of the NHS operated. This widening of knowledge will become increasingly essential as government policy unfolds, bringing GPs in primary care and NHS Trusts closer together.

A practice manager considered that:

"I don't think clinical knowledge is essential so long as you get some advice. Obviously you have to know, if you are going to be dealing with contracts and things, differences between certain procedures, if you are looking at prices and things like that, but as long as you have a clinician who is going to put that clinical input in for you, then I don't think it is essential to have clinical knowledge. I think really what you should be doing when you are talking about making contracts is that you should have a team approach, it shouldn't be one person doing it anyway."

(Practice Manager)

A Locality Manager considered that:

"No, I don't think clinical experience is essential to be a manager. I think if you have got management skills it does not matter what your background is."

(Locality Manager)

An organisation and development manager considered that:

"I think clinical experience is essential, but only at certain levels. Not so much at senior level, I think it is essential at first line level to have a really good understanding of the actual service that is being delivered, so if that is in a clinical part of the organisation, then I think it is essential to have some clinical knowledge at first line level. At more senior levels I don't think it is as essential, there are examples of very effective managers who haven't got clinical backgrounds, as long as they know where they can go to to get the advice, it is the managerial skills which are more important perhaps at senior level, if they have got both, well that is desirable, but not essential."

(Senior organisation and development manager)

Another respondent considered:

"I do not see clinical experience as a pre-requisite but it is an undoubted advantage, a bonus to have. In terms of the managers having clinical knowledge themselves it is not absolutely essential, but if they haven't got it, it is particularly important that they have access to those who have that knowledge."

(Chief Officer, Community Health Council)

One academic respondent I interviewed felt that an understanding and an ability to listen are more important than having clinical knowledge. She knew of instances from a large teaching hospital where each specialty gave a presentation about where they are now, what they are doing, what are the issues confronting them and this is where they would like to go. This approach, she considered, had really helped them to get a much better grasp of the issues being faced by each specialty within the hospital. In her opinion a Medical Director can understand the clinical terminology better, but you may not have a Medical Director with the managerial skills that a Chief Executive would have, so from that point of view you may not need to have direct clinical experience, but you need to have an ability to listen to the clinicians and to learn from them, to learn from what they are saying and to keep up to date, to a certain extent, with the medical literature. It was important, she said, to "Read the BMJ (British Medical Journal) as well as the HSJ (Health Service Journal)."

The majority in this group felt that it did not make any difference whether the manager was a doctor, non clinical manager or other health professional. They felt that it was useful, but not essential, to have some form of clinical background in terms of managing health care,

because this background enabled people to understand the language and to access a whole area of useful clinical knowledge but if you have management skills, it doesn't matter what your background is. There was a variety of opinions, however without exception, they all stated that it was essential to have respect for clinical issues and access to clinical advice was crucial.

I detected varying strengths of feeling amongst my key informants in relation to these questions. There was however complete unanimity on the need for clinical advice to be readily available. Some informants expressed the view that if non clinicians were so heavily dependent on clinical advice from medical consultants then the clinician might as well be the one taking the decision. The majority view was that clinicians, be they doctors, nurses or other clinical professionals, could acquire and practice management skills to supplement their clinical knowledge, the non clinician however could not realistically acquire nor practice clinical skills.

In the next chapter I shall continue analysing and discussing fieldwork data including data from doctor managers operating in clinical directorate systems.

CHAPTER NINE

THE NATURAL MANAGERS?

In this chapter the views and opinions of my respondents, who were all asked the same main questions in relation to doctors in management, are analysed. These include those of Medical Directors and Clinical Directors involved in the Clinical Directorate systems, the implementation of which has enabled many doctors to become involved in management. Some regard the appointment of clinical directors as marking the beginning of "An exciting phase in medical management" (Marnoch, 1996, p47), providing doctors, for the first time, with an organisation and management structure which allows them considerable scope in decision making and the use of resources, and which at the same time makes them accountable and responsible for their actions. These are key features which were lacking in some of the other attempts to involve doctors in management.

The purpose behind this analysis is to try and build

up from the interviews a picture of doctors in management and the extent of their involvement. Had they merely skimmed the surface of management, had they only become involved in those areas which interested them most, or had they delved into the difficult managerial areas of resource and staff management, decision making, strategic planning, setting the direction, having a vision of the way forward and so on? How far would the analysis of the research data suggest that they are "the natural managers?"

In chapter 6, I outlined the method of operation of the Clinical Directorate system. In this chapter, I shall examine views on the evolving role of doctors in management leading up to an analysis of impressions and experiences of informants who are either directly involved in the Clinical Directorate system or whose duties bring them into contact with that system. The latter part of the chapter is devoted to an assessment of my main research question of whether or not doctors can be regarded as "the natural managers" and if so, what are the implications. Also included is an analysis of the associated research question I have addressed throughout this thesis, relating to the importance of the blend of power and authority in the management of the NHS.

THE EVOLVING ROLE OF DOCTORS IN MANAGEMENT

In this section I wanted to explore how the role of doctors in management had evolved over the years, as seen through the eyes of respondents who had many years of NHS experience. These respondents had viewed the changes and seen the role develop to the present level of involvement.

A Consultant Physician, who occupies the post of Chief of Service, (which is in effect an extension of the post of Medical Director, used in the largest hospitals), explained how, in his opinion, the role of doctors in management has evolved emphasising the shift from informal involvement to formal accountability:

"The role of doctors in management has moved from the informal to the formal, very much so. In the past I don't think some people realised they were managing because it was informal with no accountability, now this has changed to a more formal, accountable role. The days of being involved in decision making with no accountability have gone for medical staff. I think the future will see more active medical involvement in management, alongside others. There must be a mix of skills, I think doctors realise they have to be part of the management process and I think this will increase."

(Consultant Physician (1) Chief of Service)

The following extracts are from interviews with two Clinical Directors relating to the evolving role of doctors in management:

"It has moved mainly from an informal

involvement with a few senior consultants interested in management to a now more accountable involvement and a real say in the future of the organisation."

(Consultant Anaesthetist, Clinical Director)

"More formalisation, more accountability, more responsibility. I think the evolution of the Clinical Directorate system provides a possible solution or part solution to the problems of managing the NHS. If this is well developed and thought out it has a number of very distinct advantages over other systems, many of which have been tried and failed. The direct involvement of doctors in decision making with the very important aspects of responsibility and accountability which are part of the new Clinical Directorate system gives doctors authority and is a development which I like and which the majority of other consultants are coming to recognise as the way forward."

(Consultant Paediatrician, Clinical Director)

All these informants emphasise the element of accountability which was lacking in doctors' previous involvement in management. The general feeling was that if they have to carry the burdens of accountability and responsibility, it follows that they must be involved in "real" decision making.

I asked a senior consultant about how the role had evolved:

"The way in which the role of doctors in management has evolved culminates in the role now occupied by the Medical Director. He is there to see medical fair play. The Medical Director is there to face up to all the items that come forward onto the Trust Management

agenda and he has to bring, to the best of his ability, the medical aspects of that particular item, to warn about the possibilities if a particular course of action is taken, to warn about shortcomings, he has got to give his medical advice to allow the Trust to do the right thing in providing health care, because that is what it's about. He will know his colleagues, hopefully has the trust of colleagues, will know what the Royal Colleges are thinking, the development of training, how services can be provided, he will know what the finances are like, he will have to translate these back to his colleagues and introduce discussion regarding new developments etc. He is a key figure there. He has to have a profound knowledge and interest in the medical scene and in setting the direction, and he has to be prepared to go and ask questions of consultants and bring the answers back. So he is a key figure in providing what the Authority or what the Trust has to do, which is to meet government policy within the constraints of the financial situation."

(Retired Consultant)

The views of this respondent stress the importance of the clinical voice being heard at Trust Board level. This had implications for the role of the (usually) lay Chief Executive. With the implementation of the Griffiths recommendations there was a belief that the Chief Executive would and should be in overall charge of the organisation. However, this rejection of a team approach to leadership posed problems, since the lay Chief Executive did not have any clinical responsibility. At present, this is the responsibility of medical consultants who have traditionally discharged that responsibility individually. However, increasingly on clinical matters,

the Medical Director or Clinical Director is responsible. This issue was highlighted recently in the tragic events at Bristol Royal Infirmary culminating in 1998 (see chapter 2 pp64-65), where the Chief Executive, despite being a qualified doctor, denied any clinical responsibility. He argued that "crossing the bridge" from being a doctor to becoming a full time Chief Executive of an NHS Trust meant that he could be held to account only as a manager and that he had to rely on the expertise of medical colleagues over clinical matters (Healy, 1998, p6). However (because he was a doctor) he was brought before the General Medical Council's professional conduct committee and subsequently (subject to appeal) struck off the register. The implications of this case suggest that medically qualified Chief Executives have extra responsibilities to those of lay Chief Executives (Health Service Journal, 1998a, p4). The implications of recent clinical governance reforms for the responsibilities of *all* Chief Executives in relation to clinical practice are not yet clear, but also may be substantial.

The main emphasis from doctor respondents was how the role had become more formalised with responsibility and accountability as key features. These respondents however did not seem to have any problem accepting managerial responsibility and accountability, (indeed they

seemed to relish the prospect!) They had always been responsible for the treatment of their patients therefore adding the management dimension seemed to them a natural progression. These were, however, people who had opted for a management role. There is a question therefore as to how far they are representative of the profession as a whole. This is relevant to the "succession" issue discussed later (see pp354-358).

CLINICAL DIRECTORATES

Clinical Directors are part of a line management structure. In some instances they report directly to the Chief Executive (to whom they are managerially, but not clinically responsible). In other instances they are part of a line management structure with the Medical Director as their immediate boss (Marnoch, 1996, p56). A sample of organisational structures from some of the locations I visited and from others show the different lines of responsibility in various clinical directorate systems. These are included in Appendix X. As can be seen from the structures, a considerable range of clinical services are often grouped together to form one directorate, with, in some instances, the Clinical Directors being called Associate Directors and responsible to the Director of Medical Services. However, there would appear to be no one way in which Trusts have brought

doctors into management, there seems to be no common structure. This is understandable given the complex network of services to be covered in some of these very large organisations. Suffice to say, these specimen structures serve to illustrate the extent of the Clinical Director's responsibilities for managing and being accountable for these services.

It is interesting to see, in the clinical directorate system, the way consultants seem to have accepted their accountability to the Clinical Director, typified by these comments from a Clinical Director:

"I have had little or no difficulty with consultant colleagues in getting them to accept my position as a manager as well as a clinician. I have had considerable support from consultant colleagues and others in the Directorate and in the Trust."

(Consultant Histologist, Clinical Director)

This is in direct contrast to the old "Cogwheel" system where consultants refused to be accountable to the head of their "Cogwheel" division (who was also a consultant), a situation which contributed to the system's demise. This development may reflect a growing awareness by consultants that while individually they are at risk of managerial control, in a clinical directorate system, headed in the majority of cases by a medical consultant,

their collective power more than compensates for this loss of individual autonomy.

A number of respondents talked about the development of the clinical directorate system:

"This system is of course a new venture and whilst here it is quite well developed there is still a lot to do to develop the system even more, however it is a good system which makes it attractive for doctors to become actively involved in management."

(Consultant Paediatrician, Clinical Director)

A Chief of Service felt that:

"I think it has a lot of advantages, I think it is better than we had before, he who shouted loudest, emotional approach to things, it is a much more measured approach. It does enable you to see, for example, the lack of knowledge many lay purchasers show on the services we provide in specialist areas. There was this belief that patients were going to come into hospital, have an operation and go home cured. They had forgotten about the vast number of patients who are getting continuing care of one sort or another. They had forgotten about the diabetic patients who come in to see a diabetic physician, those diabetic patients who become pregnant, follow up care etc. They had forgotten about the cancer patients who maybe come for years having radio therapy, chemo therapy, who never go to their GP because they are getting continuing care, and in my own specialty which is renal medicine, they had totally forgotten about the patients who come in and are on a dialysis machine for 20 years or so and then get a kidney transplant who never go to their doctor because their doctor does not know how to look after dialysis patients. When they have a problem they ring us up and come in, they have open access. The reforms were not designed for this continuing care system and I

think to some extent even the management system didn't really work to solve that problem. It has taken us a long time with the purchasing authorities to get this into the system and we have a long way to go yet, but at least the new organisational structure allows us to have these discussions with purchasers."

(Consultant Physician (1) Chief of Service)

A number of important points emerge from this respondent's reply. In particular, he identifies a huge gap in the contracting process regarding continuing care patients. From his point of view, the clinical directorate system afforded him the opportunity to correct this deficiency and to enable him to take corrective action with purchasers, action which was not available to him before.

KEY ROLES IN THE CLINICAL DIRECTORATE SYSTEM

For the purpose of this analysis I shall be looking at the key roles i.e. the role of the Chief of Service, the Medical Director, and the Clinical Director.

A Chief of Service, explained his role to be:

"Co-ordinating and planning. I think these are important parts, looking ahead, a lot of people do the operational work, the day to day, I have to look at the business planning, one or maybe five years ahead, just like the captain of a ship, you want to make sure everybody is pulling in the same direction and pulling together and making sure everyone knows the direction we are going. A big part of my job is getting the support, and retaining the support of my peers. To consider

and balance all the competing arguments for resources etc."

(Consultant Physician (1) Chief of Service)

This element of retaining the support of colleagues is a distinctive feature in the operation of the clinical directorate system. Without the support of his/her consultant colleagues the Medical Director (and indeed the Clinical Director) cannot function effectively, he/she becomes a failed Medical/Clinical Director.

"I see the role of Medical Director as a co-ordinating, harmonising role, success depending in large measure from the support of consultant colleagues. We have 5 clinical directors, we have contracted down from eight or nine to five."

(Consultant Physician (3) Medical Director)

It was felt by this Medical Director that the doctor's role in management should become much more established than it is at this present time:

"I think the role of Medical Director will probably strengthen. I think doctors will have to ensure that they have more management skills and I think we have the opportunity through Calman to put in modules of management training. I think we will see some issues raised even at an earlier level, at undergraduate and immediate post graduate level. I think people like myself are bound to influence the more junior level of doctors to believe that it is right to get actively involved in management, they will see that our being able to get things done through our involvement will have an influence on them to get similarly involved. We have a small proportion of doctors interested in management here who are exceptionally good, you will only

find these by offering them the opportunities to learn about management and to get involved in management."

(Consultant Physician (3) Medical Director)

I outlined one of the problems highlighted during my research which has been the problem of how doctors retain clinical credibility when they become a manager. If they become too much of a manager and remove themselves too much from the clinical field they have less standing with their clinical peers.

ME: "Is the ideal doctor manager someone who is still involved say 80% of the time with his/her patients and the remainder involved in management but at the very top end of management?"

"Yes I think you are right, you have got to maintain clinical respect amongst your colleagues and that probably involves doing at least 6 clinical sessions per week, in terms of my time about 30% of my time is spent as a Medical Director, 70% doing clinical medicine, but that's a very extended week. I often have to extend the end of the days really."

(Consultant Physician (3) Medical Director)

Another Medical Director stressed the importance of the team approach together with the need to promote the professional development of staff within the directorate. The emphasis on team working within directorates was a feature of the management style most Clinical Directors had either adopted or wished to adopt, together with the

utilisation of the considerable talents within the
directorate.

"Having been a Clinical Director, the role for the Clinical Director is to manage with the team, the directorate for which you are responsible which means that you are accountable for the directorate's budget. It was important to be a leader and a high profile person that other members of staff can relate to as well as being able to develop good communications both within and outside of the team. It was of the utmost importance that communication systems are well developed. The Clinical Director has responsibility for doing that and all the other things like making sure the business plans are produced, getting the contracts, facilitating, so that people can take educational opportunities and be able to implement new developments, carry out audits and generally develop their considerable potential. Clinical Directors have a strategic contribution to make to the Trust itself, some directorates have become mini businesses within a Trust. It is quite important that there is some corporate action as well, otherwise you find the directorates are all going in different directions, they have to operate within the direction that the Trust Board has set and they must also contribute to setting that direction as well."

(Consultant Psychiatrist, Medical Director)

The co-ordination of work with other consultants and other directorates was considered by a Clinical Director to be part of his role as well as monitoring performance within his directorate to ensure that the business plan was being adhered to and that contracts were fulfilled:

"Overseeing the whole of the clinical work, starting with things like working with my colleagues to produce a business plan, and then ensuring that the business plan is

properly agreed, organised and monitoring it throughout the year, making sure that we are keeping in touch with all our contracts, and co-ordinating some of the activities between the various consultants, between junior medical staff and the other directorates."

(Consultant Obstetrician and Gynaecologist,
Clinical Director)

Another Clinical Director placed importance on getting doctors involved and participating with the other staff in the directorate. The team work approach mentioned by this respondent is an important feature of the operation of clinical directorates:

"To get the doctors on board. It is to manage this medical service that we are selling and to get the medical community to work with other staff in the directorate and to take a real interest in making the system work. I have to get them to work efficiently, not waste any resources, to get the contracts done. I have to be given the authority and the funds so that when all goes well and we have done all these things there is some reward for the department, not necessarily for the individuals, but something the department requires i.e. medical equipment, office equipment, or in new technology that has been introduced, they want that sort of reward. Now that has to be managed, because more costs flow from these purchases, not least when these additional items need to be serviced and ultimately renewed. You have all these people and you try and support them to make them better players, you try to harmonise all of them so that you get a team effort."

(Consultant Anaesthetist, Clinical Director)

A Clinical Director considered that a key role for the Clinical Director in the system was to exercise

authority, although in his remarks he clearly favoured consensus whenever possible:

"Authority to undertake strategic planning for his directorate within the corporate aims of the Trust. I have to have a business plan for my directorate, I must involve many people in this planning process. I try and reach a consensus in the discussions I have with people, and in the main we do, however if I cannot reach a consensus decision then I must take the decision myself, based on my knowledge of the corporate direction of the trust, of the resources available to the directorate, of our ability to deliver the decision and so on. It is therefore a harmonising role, getting the best out of the considerable talents within the directorate, getting the co-operation of consultant colleagues, acting as gatekeepers, acting as honest broker between management and the clinicians, demonstrating that you have the skills to do the job, the ability to get things done."

(Consultant Paediatrician, Clinical Director)

On the question of accountability, I posed the question to a Medical Director as to whether the Clinical Director was accountable to the Chief Executive, or to him:

"The position here is that the Clinical Directors are responsible to me on clinical matters, but for non clinical matters are responsible to the Chief Executive."

ME: "Do you regard this as a weakness or a strength"?

"I think this is a strength. I know some people do have an arrangement whereby the Clinical Directors are accountable to the Medical Director but that is not the position here. One of my roles is communications, when these start to go wrong, and they

sometimes do, the structure breaks down for one reason or another, then I have to ensure that I facilitate reasonable communication with top management and try to resolve the matter. The prime role is really to bring the Trust Board into some recognition of the balance of importance between competing priorities in their strategic plan. The finance side of things is delivering health care against trying to have an efficient organisation, it is really at that strategic level that the Medical Director is important, that is the only medical voice up there."

ME: Do you sit on the management committee?

"Yes I do that as well. I think we have a slightly flawed structure there in that most of the major operational decisions are taken by that group, so there is too much centralist control of what is going on. We keep moving away from it and then returning to it, that does threaten the directorate structure, we do have strong directorates, they are largely independent, but we still do tend to dictate some of the major decisions. It is very difficult to get to the level of maturity that can resolve this matter."

(Consultant Physician (3) Medical Director)

With regard to contracting arrangements I asked this Medical Director if he and/or the Clinical Directors were involved in the contracting arrangement:

"I am not. The Clinical Directors are, but rather remotely. We all (maybe to do with our specialty interests) give advice, but most of it is done through our business planning organisation, rather than the directorates. We do have a business planning cycle and so forth and build that into the contract expectations both ways."

ME: "Are you able to express your views about contract requirements before the contract is negotiated or are you just given the completed

contract and told to get on with delivering the contract requirements"?

"No, we do have mechanisms to try to ensure that if we do have developments or additional services to offer they are built into the process, but I would still describe this as very crude. This is a new and evolving process."

(Consultant Physician (3) Medical Director)

It is interesting to see how the important aspect of contracting is largely delegated to the business manager by both the Medical and Clinical Director. Winning contracts form a substantial part of the income for the directorate and one would have expected a more involved role in this for the Medical/Clinical Director although they are involved in the business planning cycle.

SESSIONS PER WEEK AND DURATION OF APPOINTMENT TO MEDICAL/CLINICAL DIRECTOR POSITIONS

Respondents were asked their views on the best number of sessions per week and duration of appointment for Medical Directors and Clinical Directors. Most thought that the appointment should be for two or three sessions per week, with the duration of appointment being three to five years renewable. This would ensure that the majority of time was still spent in the clinical field, which was felt to be essential in order to retain clinical credibility.

A senior health executive official said:

"Appointments should be part time for a fixed period. The most capable of the clinical directors will want to return to their full time clinical role and will see the time spend as a Clinical Director as useful experience for a limited time adding to their overall experience."

(NHS Executive, Senior Official)

A Director of Public Health pointed to the variations between organisations:

"It depends on the organisation. As an example a friend of mine was a Clinical Director at the Newcastle RVI with 2 sessions per week and that was about right. He was trained to do it in that time, within his normal working week. I know some people do their Clinical Director sessions in addition to their full week clinical commitments, but I doubt whether this is taking the Clinical Director role seriously. If you intend carrying out the role then you must be given the time in which to do it."

(Director of Public Health)

A Medical Director took a similar view, although with a larger estimate of the time the job demands:

"I think one session per week is absolutely ludicrous. In a large directorate like mine, that is just stupid. I used to reckon that I needed about six sessions a week as a Clinical Director, and still have a full time clinical work load. That is the dilemma, this time business, fitting it all in, we all work extra, but often enjoy it and feel we are being effective."

(Consultant Psychiatrist, Medical Director)

I asked a Director of Public Health what he thought regarding the duration of appointment to Clinical Director positions:

"I don't think there is any answer, it depends on the enthusiasm of the individual, the skills of the individual to do the job etc. You want someone who is committed to the job and who will not walk away from it say in three years time. They are making big long term decisions and ideally will stay in the role for longer than three years."

(Director of Public Health)

A Medical Director stated that in her organisation:

The duration of appointment is usually 3 or 5 years renewable."

(Consultant Psychiatrist, Medical Director)

THE SUCCESSION DEBATE

I asked informants whether they thought doctors will become more actively involved in management. The majority of my informants felt that the new type of involvement for doctors in management which the clinical directorate system affords i.e. with a formal position in management, with real managerial responsibility and accountability and real decision making powers, was an attractive prospect, but much more needed to be done to encourage doctors into management. I asked respondents if they thought there was growing interest amongst consultants to take on the role of clinical director.

The majority opinion was that this was not so, typified in this reply from a Medical Director:

"No, not really not at the moment. I think we just about have enough to maintain the succession. I think the other problem for consultants really is fear, they wouldn't be in a big institution like this if they hadn't already been extremely successful in a number of different arenas, i.e. to get their degrees, their medical qualifications, their consultant appointment, and so on and then at the age of say 45 they are asked to take on a completely different set of roles within a different cultural setting. I think that is why people are so hesitant when they first go into these roles, they don't know what the rules are, they don't understand the potential power and influence that they have and they are frightened of failing because they are essentially very successful people. When you don't understand the rules or the language or understand that there is a very big area of management thinking and training you need to assimilate in a very short period of time, in addition to the considerable amount of clinical knowledge and responsibility in a consultant's clinical role, it can be a daunting prospect for some."

(Consultant Physician (3) Medical Director)

A Director of Public Health alluded to the problems of succession:

"A lot of the first wave of Clinical Directors saw the clinical directorate system as an opportunity to move into management, but as it got harder then it became more difficult to maintain their enthusiasm."

(Director Public Health)

"I think there is some interest in becoming a Clinical Director, but I think it needs to be more formally encouraged. There are considerable advantages which Trust Chairs and

Trust Boards need to recognise much more, in order that this involvement can be further developed."

(Consultant Paediatrician, Clinical Director)

All informants stressed the need for succession planning to avoid problems of dis-continuity. One informant felt that:

"It would be an ideal situation for the better of the Clinical Directors to continue as such, this would overcome the problem of succession, but it is doubtful if they will. The fixed term nature of the Clinical Director appointment allows those less capable in this role to be replaced. This was one of the problems of doctors in management before i.e. in general only those doctors who were less committed and less capable were interested in the management role even though at that time the management role was informal with little or no managerial accountability."

(NHS Executive, Senior Official)

I asked a Medical Director if she had any succession problems in the clinical directorate system in her organisation:

"Yes, it is a big problem, it is very difficult. I'm sure most Trusts attempt to do succession planning, but with little success."

(Consultant Psychiatrist, Medical Director)

This is an important matter which doctors who intend becoming involved in management have to consider. My

doctor manager respondents were all positive and enthusiastic, but there does not seem to be many doctors "waiting in the wings" to take on a management role. This presents a real succession problem for Trusts. Some Trusts are trying to tackle this. One which I visited during my fieldwork has included in the job description of its Medical Director a key requirement "To develop and facilitate the participation of Consultants in management." (Appendix VIII). Clearly the continued involvement of doctors in management, which is almost always temporary and part-time, is dependant on a sufficient number of doctors wanting to become involved. If existing post-holders carry on in management, they may lose touch with the clinical field. If others do not wish to become involved, this suggests a flaw in the whole system. So how can the continued involvement of doctors in management be ensured? The origins of this lack of interest possibly go back to medical training curricula which have not included any reference to the basic structure of the NHS, nor to the development of such skills as leadership and strategic planning. The Academy of Royal Colleges of the UK recognise this deficiency and have unanimously adopted a report from the Scottish Royal Colleges, which includes a core curriculum for post-graduate clinicians across the UK and in all medical specialties which will include these matters (Health

Service Journal, 1998, p6). Whether this necessarily means more doctors will want to be managers, only time will tell.

It was interesting to see that whilst those doctors who have become doctor managers regard their management position as prestigious and as enhancing their status in the organisation, there was no sign of large numbers of other doctors striving to achieve these positions. One explanation is because the position involves considerable commitment not only from a time perspective but also because of the amount of additional knowledge which needs to be acquired. As one Medical Director mentioned, some doctors are fearful of taking on these additional burdens in addition to their clinical workload. It is for some, as he said, "A daunting prospect" (See p355). These are valid reasons and point to the importance of the "succession" debate which needs to be taken seriously in order that sufficient doctors are encouraged to take on this management role.

ADVANTAGES/DISADVANTAGES OF BEING A MEDICAL/ CLINICAL DIRECTOR

The majority view was that the advantages outweighed the disadvantages of taking on a management role. A Chief of Service felt that there were few disadvantages. He

considered that the clinical directorate system was working very well and that Clinical Directors made good use of their financial and organisational control.

A Medical Director argued that representing the clinical perspective remains a difficult task:

"From a personal point of view there are some disadvantages because your own perspective is relatively weak at the top of the organisation, certainly in the management executive team, I am only one clinical voice amongst six. On the Trust Board I am only one of two clinical voices if you include the Director of Nursing. So there are only two clinical voices, there is a frustration there. The advantages are that at least there is that representation and that both those groups, nursing and medicine, tend to get a lot of respect and so you can influence things quite strongly if you wish to."

(Consultant Physician (3) Medical Director)

A Medical Director felt that the disadvantage is in the amount of work there is to do in the role which by definition must impinge on clinical time, whilst a Clinical Director felt that the advantages are that the role enables you to "control your own ship", you are able to make things happen, to control the destiny of the directorate, have a say in change, to take responsibility for the directorate, to make important decisions etc. The biggest problem, identified by almost all my clinical respondents is the extent to which their involvement in management impinges on their clinical work. Time

constraints and getting people to understand the volume and complexity of the task were highlighted by respondents:

"Time constraints are there, there is a lot of work, and at the moment we do have good nursing teams and so on. External constraints are there, i.e. the purchaser negotiations are extremely important as are the financial constraints of course. Some controls are essential controls but some areas might still be devolved to us."

(Consultant Paediatrician, Clinical Director)

"Time is a major problem. The difficulty for a Medical Director, (and this is an average Trust of some £60 million budget), it is very difficult for me to promote anything more than a broad strategic idea about things, I can't get down into the detail of what is happening in paediatrics or in A and E or my own specialty because, from a time point of view, it is impossible, it is very difficult to bring all of those equally important and complex issues up at a top level. We do have one of the management directors who is meant to represent that, but I think that is difficult for any individual, because I think that is the difficulty of delivering health care, it isn't like a single big product line, you have a huge range of very individual issues which are very specific for the area of health care, for example delivering community paediatrics to the schools is quite a lot different to delivering endoscopies for open access services to GPs, and you could list 200 of those different sorts of things and how you then build that into something that is a coherent whole at the top of the organisation is very complex and difficult."

(Consultant Physician (3) Medical Director)

Another respondent referred to the constraints of time in the clinical director role. He felt that the

system is working quite well now, although at first they had been largely excluded from some of the important decisions.

One Clinical Director considered that the considerable range of knowledge which the Clinical Director has to acquire to carry out this role effectively can be a major problem. He felt that in addition to the clinical knowledge which is needed to gain the respect of clinical colleagues, the clinical director needs to be able to understand the finances of the Trust, the budget, the contracting procedures, organising skills, motivation skills, staff management, legal issues, personal issues, change management, time management etc.

WHAT IS THE MAIN ATTRACTION FOR DOCTORS TO BE INVOLVED IN MANAGEMENT?

The most common feature, evidenced by these interview extracts, was to be able, as they put it, "to get things done."

"If we are talking personally, I think it is a huge challenge and I personally like the challenge. I think it is enormously interesting, its very rewarding, you get quite a kick out of things that you achieve and do well, that's the real thing. Motivations are likely to be different. Some see it as being able to get things done and move things forward."

(Consultant Psychiatrist, Medical Director)

"Mainly to get things done and to be able to influence decisions. To be able to take

decisions to improve the running of your Directorate and to be accountable for these decisions. To actually see things happen as a result of your considered decision which adds to the effectiveness and efficiency of the Directorate."

(Consultant Paediatrician, Clinical Director)

"Getting things done, although there is a dilemma here. I suppose as one gets more senior, either your confidence increases or you can see things in a wider view, so you want to move and change things and make improvements."

(Consultant Obstetrician and Gynaecologist,
Clinical Director)

"The attraction is that it is now formalised and doctors are able to see that they have real decision making powers to provide the strong vision for the future. To be able to seed the changes. A ping-pong effect, to be able to give others the confidence to take things on board, to make things happen, to effect change, to take responsibility for big decisions. The present trend with the advent of the Medical/Clinical directorate system is irreversible."

(Consultant Histologist, Clinical Director)

A SCARCE CLINICAL RESOURCE

I asked respondents their view of the argument that it is a waste of, in many instances, a scarce clinical resource for doctors to be actively involved in management.

The general view expressed by a large majority of informants was that this was not wasting a scarce clinical

resource. One respondent, a Chief of Clinical Service, argued that for anyone to take this view was a mis-understanding of the role of the doctor in management. Many consultants in charge of departments had always managed the staff in that department. They might not have had the budgets, but they were managing the staff, often influential in deciding who should be the Ward Sister, who should come on to the team or be involved in the team. If they were managing anyway, albeit informally, the advent of Clinical Directorate systems had principally meant that their position had become more formalised.

A similar point was made by another doctor-manager:

"All senior consultants have had to use management skills on their way up. I think it is really important that they contribute to the management process. It is about participation, about getting the best deal for the patients basically and I think that they (the consultants) might be the best advocates for that. So no I don't think it is a waste of scarce time at all. I think you need to focus on what is the best output from that person for the organisation really."

(Consultant Physician (2) Medical Director)

However, almost all my respondents stressed that if this scarce clinical resource was to be used partly in a managerial role, then it must be used efficiently and effectively. For example the involvement in management must not be in the mundane day to day things. The

doctors must be involved in the bigger issues which warrant their expensive time. As illustrated previously, the importance of the doctor manager "making things happen" was stressed by a number of respondents:

"As long as you are utilising this scarce time to the best effect and not have them going to endless meetings that perhaps a business or other manager could go to then that is fine. When it comes into disrepute is if you have them doing mundane things. There is no point in having clinicians involved in management unless they actually make things happen, make a difference, they have to be demonstrating to do something in this role."

(Consultant, Clinical Director)

A Chief Executive respondent recognised the advantages that bringing a doctor into management can produce, not only for the organisation but for the doctor himself/herself.

"Taking doctors out full time into management, they really have to demonstrate their worth there, but taking them out part time or sessionally from their active clinical tasks, is quite good, if anything it has a real productivity. It is refreshing for them to have one or two sessions per week when they are doing something different, but it has to be at a level for them to be able to make a difference because otherwise it could be a waste of a very costly resource. They must be involved in real decision making. It can bring a freshness of approach and a new dimension to the management process which is stimulating for the whole management team."

(Chief Executive, 6)

A GP respondent considered that:

"Most clinical doctors do not want to get involved in management because it undermines their clinical time. Once they do see that there is obviously a need for them to be involved in management to direct the way management decisions are going which have clinical implications, then there is no waste of clinical resources, but there is a balance between the two. So the actual scarce clinical time is definitely a big problem. The only way I see around that is first of all, training doctors in some management techniques to start with in their basic training, then skilling them in some management techniques, and making them realise the importance of management involvement. As that time is taken out, fund the replacement time."

(General Medical Practitioner)

The "new style" doctor in management responsibilities are highlighted by a Chief Executive respondent who clearly differentiates the role from previous attempts to involve doctors in management. It is interesting to see that in his organisation the management work of Clinical Directors is in addition to their full time clinical commitment. Some would argue that this does not do justice to the role of the Clinical Director in that if the doctor manager is to carry out these duties effectively then he/she must be given the time to do so. In almost all the other organisations visited, specific sessions per week are allocated for Clinical Director managerial duties.

"Anyone who takes the view that it is a waste

of a scarce clinical resource demonstrates a lack of understanding of what management is about. Anyone who takes this view obviously thinks of the doctor in management as a half an hour here and half an hour there talking about things she/he would regard as a waste of time in terms of management. If you talked to that same person about some of the innovations currently being tried in health care, of the medical legal consequences of particular courses of action, then this becomes a matter of vision, about direction, about objectives, etc. The way the directorates are organised here, the clinical director is paid one session per week, outside his clinical work. Clinical Directorate meetings etc are outside of the clinical work, so there is no waste of scarce clinical resources because the clinical directorate work is in addition to the clinical work."

(Chief Executive, 1)

"Well, scarce specialties, you will remember, there was this scarcity of Radiologists some years ago, but they did something about it and got over that. Anaesthetics has always been something of a scarcity, so an answer would seem to be, yes it could be a waste, but I think the correct answer really is no, it isn't a waste of a scarce clinical resource. It may be apparent they could be doing an operating list but really the views of these people are as essential to the management of what is going on as any other and they need to be in there."

(Retired Consultant)

"At interview panels appointing doctors the answer had always come back from the younger generation of doctors, "No, we need to be involved, we need to help to sort the issues out, set the priorities and agree where we are trying to go."

(Chief Executive, 3)

A small minority of respondents considered that for doctors to become managers was a waste of a scarce clinical resource, as well as a waste of expensive medical training and a loss of the doctor's time with patients. This view was typified in this reply:

"I have just returned from a conference where they were stressing that doctors should get into management. In my opinion this is a waste of the considerable investment expended training the doctor in medical skills, and removes the doctor, even if only part of the time, from the medical care of patients.

(Consultant Anaesthetist)

However, it was the general opinion that those who took the view that it was a waste had failed to understand what the "new" kind of active involvement in management meant for the individual doctor, for the patients, for the Trust, and for the medical profession.

These are interesting views and pose the question of whether doctors would have been interested in becoming involved in management before now if the appropriate structures had been in place. The rhetoric is that doctors did not want to accept accountability and responsibility, but was the real reason for their reluctance to be involved in the formal management of the organisation, a lack of a suitable management structure which the clinical directorate system now affords?

CONDUCT IN MANAGEMENT

As appointments of many of the first group of doctors in management positions are coming to an end, I wanted to know how those doctors who have been appointed to management positions have conducted themselves in this role. Do they see the wider implications of decisions, both clinical and non clinical and the wider use of resources which a manager is required to consider?

There was a majority opinion from my informants, both clinicians and non-clinicians, that doctors who had become managers, either as Medical or Clinical Directors, had embarked on their new role with a high level of commitment, enthusiasm and indeed pride. This may seem an idealistic view, but these doctors in management positions carry with them high status in the organisation and for some, these positions are becoming part of their career progression. According to my informants, there was a marked difference in the way these doctors in management viewed their new managerial role compared to those doctors who, prior to the advent of the Clinical Directorate systems, had taken on a type of informal managerial role by virtue of being chairman of a Medical Advisory Committee, or as a medical representative on some other powerful committee, nationally or locally. There was a

perceived shift in the type of doctor who becomes a Medical Director or Clinical Director from consultants who used to wield the greatest informal power in the prestigious specialties, to the (generally) younger consultant who is prepared to carry responsibility and be accountable for his/her actions. This was also associated with a shift in power between specialties: The "cinderella" specialties such as paediatrics, obstetrics and gynaecology, which were previously relegated to a lower level of influence were better represented in the clinical directorate system.

As one Clinical Director commented:

I think it has taken me, some five or six years working towards this position, going on various courses, reading etc. I wouldn't like to drop out of management and then repeat that process again.

(Consultant Obstetrician, Clinical Director)

This view of management as something towards which doctors aim accords with the opinion of Marnoch (Marnoch, 1996, p47) who talks of the attractions of the position which marks the beginning of "an exciting phase in medical management." This is in direct contrast to the former situation whereby doctors were often pushed into informal

management positions on Medical Advisory/Medical Executive committees by colleagues, for no other reason than to represent their medical interests.

In general doctors took on Medical and Clinical Director positions at a much earlier age in their consultancy, than was the case of those doctors chairing MACs/MECs. My medical respondents were beginning to recognise the scope of their new powers and authority and, without exception, looked upon their management position as one involving considerable responsibilities and commitment. There was a distinct impression that they viewed the introduction of the Clinical Directorate system as a watershed. As one Clinical Director commented, "There is no going back."

WIDER IMPLICATIONS OF DECISIONS

I asked respondents if they thought doctors in management see the wider implications of decisions:

"Yes in the main I think Clinical Directors are able to see the wider implications of decisions. If you are not a visionary I think you have a very poor chance of being a good Clinical Director. Unless you are a Director of a very small directorate you can't possibly be a Clinical Director and not have a wide perspective. I think they do (take the wider perspective), although a key part of medical training is related to the one to one relationship with the patient."

(Consultant Psychiatrist, Medical Director)

The view of a NHS Executive Senior Official was that:

"Yes they do (see the wider implications of decisions) plus their clinical background adds to the quality of decisions made."

(NHS Executive, Senior Official)

A view expressed by a Clinical Director was that:

"Yes, but some are better than others in seeing the wider perspective. Doctors have always seen more than one patient because they have always worked in an NHS which was short of cash and they have managed to deliver the service economically for the overall benefit. They have always done that, there has never been a case of one to one in that sense. You will find a lot of doctors will be quite good in one to one meetings, like this one, I personally prefer that to chairing meetings and things. But there are other doctors who are very good at chairing meetings so you will find the appropriate skills in the medical profession. Different personalities, it is nothing alien to the medical profession. I think the doctor manager is able to take this wider view, ie the wider implications of decisions, both clinical and non clinical, and the wider use of resources which a manager is required to consider. He may have to struggle to get his colleagues on board to take the wider corporate view on various issues, but in general the doctor manager has been able to do this. We are perhaps fortunate here in that I have had little or no difficulty with consultant colleagues in getting them to accept my position as a manager as well as a clinician. I have had considerable support from consultant colleagues and others in the Directorate and in the Trust."

(Consultant Histologist, Clinical Director)

The following extracts from interviews with Chief

Executives illustrate their views and opinions on this matter:

"I think they now see the wider implications of decisions, they didn't at first. They suddenly realise that the branch of medicine or surgery that they have been in is very restrictive. Certainly the medical managers now do understand an awful lot more about the systems. Often the complaint is that some of them don't make as many changes as we actually think they could.

(Chief Executive, 5)

"I think doctors are getting better at managing. I think generally speaking a lot of them come to it from their own specialty viewpoint, but if I think of my Medical Director here, he is very good at being able to take a strategic view, and looking at what we should be doing. He is a consultant physician and at times he is at odds with his own division in which he is a practicing clinician because he will actually say to the consultants in his own specialty for example, "The Trust needs to do something which has a higher priority than the one you are advocating", and he will see that statement through. There is no doubt the Medical and Clinical Directors are managing their area of responsibility with a high degree of interest and commitment. I have seen a lot of very talented clinicians coming through who understand that it is about taking their colleagues along. Sometimes I think it is also about the system, understanding the role they have got to play. These people have still to work with colleagues over a long period of time.

(Chief Executive, 3)

"I think the one group who have problems thinking strategically are GPs. I think GPs, apart from the one or two here and there, only have the ability to think over the next twelve months, and a lot of them can't even do that."

(Chief Executive, 6)

"I think the majority of doctors do look at the wider implications of decisions, but it isn't a quick transition. You can't switch off on the Friday and suddenly become a Medical Director/Clinical Director on the Monday. It does take time to adjust, I think those who can't adjust drop out fairly quickly."

(Chief Executive, 4)

AUTHORITY

I asked my respondents if they had "real" authority in decisions about the use of resources such as staff, financial, planning etc. The majority view from informants was that the Clinical Director does have a substantial say. The following extracts from interview data support this view:

"Yes to all of these. Staff is of course one of the big problems when holding and controlling a budget because it forms such a large part of the budget, some 80%. I am also very much involved in planning, and budgetary allocations, certainly within the directorate but also in the hospital."

(Consultant Obstetrician and Gynaecologist,
Clinical Director)

"Yes, I have control in staffing matters, financial, planning, strategic direction and so on. I am also involved in all the business plans for each of the directorates within my division. I now have a real say in how this organisation is proceeding."

(Consultant Physician (2) Medical Director)

"Yes, in this Trust, we have a real say. Clearly there are financial constraints which I understand but yes, these matters are devolved."

(Consultant Paediatrician, Clinical Director)

"Yes, I am also allowed to appoint key staff in the Directorate. On financial matters, yes, sort of. This year they have devolved the budget, but I wasn't involved in how it was set up. It was given to me and they said, "How do you like it? Now next year I will try to be there and say before it is set, look, we will set it according to what we need. But the area in which we have a fair degree of freedom is internally. For example, the budget is set and the bottom line budget is set, how we then use it internally there is a fair degree of flexibility. We can go back to the finance department and say look here we don't want these staff costs, we are going to buy five computers and do with one member of staff less. Provided that is within the overall allocation, we can do that and there is no opposition from anybody."

(Consultant Anaesthetist, Clinical Director)

"Yes, I have total control of resources, staff, planning, financial, etc within my area of responsibility."

(Consultant Physician (3) Medical Director)

DECISION MAKING

I asked my respondents about the wider aspects of decision making. The majority response was a positive one, evidenced by these interview extracts:

"Yes decision making is devolved and this devolvement is gradually increasing. There does need to be an open form of management above the clinical directorate. This is fairly open, sometimes it is not as open as it could be, but I don't think that is a deliberate attempt."

(Consultant Obstetrician and Gynaecologist,
Clinical Director)

"Yes. I am very much involved in decision making. I consider this to be a key element

in my role, to effect change, to make things happen."

(Consultant Anaesthetist, Clinical Director)

"Yes, a high element of decision making is devolved to divisions. The Clinical Directors may feel not enough is devolved to them, but you must as the Chief of Service have some reserves to spread across the division if need be. We devolve a little more each year, some directorates have become almost autonomous."

(Consultant Physician (1) Chief of Service)

The general view from informants was that, "real" decision making was devolved to the Clinical Director. There were some added comments, for example a Medical Director felt that it is better than it was, but still not good enough.

One indication of the extent to which important decisions are taken at the Clinical Directorate level could be the agenda items for a typical monthly Clinical Directorate meeting. The range of matters discussed are very wide - for example, the following items were identified by the majority of my informants (not in any particular order of importance):-

- a) Trust matters, strategy etc, Government initiatives eg Health of the Nation, New legislation etc. New circulars/directives
- b) Changes in Clinical Practice
- c) Financial situation
- d) Team briefings
- e) Committee reports
- f) Complaints
- g) Risk management

- h) Contracting position
- i) Quarterly reports
- j) Staffing matters
- k) Medical recruitment
- l) Political matters
- m) Research matters
- n) Clinical Audit
- o) Quality matters
- p) New developments eg Mental Health
Commission issues.

It is clear from these agenda items that the range of matters discussed extend beyond operational matters and process, to include extensive involvement in the full breadth of activity in the directorate and beyond, suggesting a pro-active style of management in both its strategic and operational role. Respondents confirmed that appropriate mechanisms exist to ensure that decisions taken at Clinical Directorate meetings are acted upon and follow up action taken whenever necessary.

"THE INTEGRATION OF POWER AND AUTHORITY"

Many of the views expressed by respondents support the argument relating to the advantages of the integration of power and authority in managing health services. Without exception, these doctors in management say that the Medical/Clinical Director positions allow them to shape the direction of services, to have a real say in important decisions and to be instrumental in making things happen. This is because the Consultant brings to the Medical/ Clinical Director position the power and the

credibility which he/she has as a consultant. This power is then linked to the formal authority he/she acquires on being appointed to one of these positions, thus creating the blend of power and authority which enables him/her to have a real say in the organisation and management of the service and in the use of resources, not least clinical resources.

There was a general opinion amongst all my informants that consultant medical staff had always had power, but there had never been a system to harness this power into active formal involvement in management. The introduction of Medical Director posts and the clinical directorate systems had changed that. The Medical/Clinical Directors were now shouldering this responsibility and accepting accountability for their actions, both for clinical and non-clinical matters. With these appointments, they acquired the formal authority which they had lacked in previous management structures. They recognise the need to develop the talents within the directorate and had the means to do so. They now had the blend of power and authority which was enabling them to effect change and to have considerable influence in the use of resources, not least financial and staff resources.

DOCTORS AS CHIEF EXECUTIVES

The general opinion from my informants was that whilst there was some interest in doctors becoming Medical/Clinical Directors, there was not a great deal of interest in going on to become Chief Executives, mainly because that would entail a full time management post, which clinicians in general did not wish to undertake.

A Medical Director informant said that:

"I don't really know about going on to become a Chief Executive. I think it depends how interested you are in developing management skills. I think it is a great pity if somebody becomes a Clinical Director say in their 40s and then stops being a Clinical Director and doesn't do anything else managerially. I think they have a wealth of experience that is then lost to the Trust. So I think it is quite difficult to see, what next. Undoubtedly some people do go on to look at Chief Executive posts, but not many because this generally means full time in management, thus leaving the clinical field altogether. Personally I wish to concentrate on being Medical Director."

(Consultant Psychiatrist, Medical Director)

Other informants felt that there would be limited growth in this area. Some Clinical Directors hope to become Medical Directors after a while but do not, in the main, wish to aspire to full time management positions such as Chief Executive. Management positions which remove them entirely from clinical involvement are not on the whole attractive propositions for the doctor in

management. The feeling was that they then lose the prestige and influence which clinical skills bestow. In the opinion of one Clinical Director:

"I want to be a part-time doctor manager but I also wish to spend the majority of my time working in the clinical field as a consultant."

(Consultant Paediatrician, Clinical Director)

There is no financial incentive for them either. In fact, if they have private practice, they could lose income by becoming a Chief Executive.

ARE DOCTORS THE NATURAL MANAGERS?

As stated earlier, behind much of the questioning throughout my fieldwork there was an attempt to assess the extent of active involvement doctors had in management. Was it a superficial involvement or were they really tackling the difficult management areas as well as the "shop window" areas? From the data, the impression I gained was of a responsible and committed approach, even in the difficult management areas, suggesting that their involvement was "real." They were prepared to accept the high levels of responsibility that active formal involvement in management entails and were prepared to take decisions when necessary at variance with the wishes of their clinical colleagues. These doctors attached great importance to Medical Director and Clinical Director

positions. They regarded these as "prestigious doctor in management positions" (Consultant Physician, Medical Director) even though none of them at medical/clinical director level gave the impression that they wanted to "lead the field", or become involved permanently or full-time. They were interested in dialogue with lay managers provided they had a real say in decision making and that they were allowed to do their clinical work without too much interference. Salter contends that "Clinicians will do sufficient management to protect their professional patch at the clinical directorate level but will not attempt to take over the demanding quasi-political role of senior management in the Trusts" (Salter, 1998, p220). However, the interview replies from my doctor manager respondents suggest that they are willing to take on this "quasi-political" role but not full time, not permanently and not as Chief Executives.

The analysis of the data generated by my interviews with respondents therefore suggests that these doctors in management have not just "skimmed the surface", but have in fact become very much involved in the whole range of management issues. However my research found a variety of opinions on whether or not doctors are "the natural managers." The following analysis includes extracts from informants expressing their different points of view.

Some informants felt that no one professional group could be regarded as "the natural managers." The lack of clinical expertise of lay managers can pose a challenge to their credibility and thus to their position as the "natural managers" of the NHS. However, there would appear to be, in the opinion of the majority of my informants, no one model. One respondent, a Director of Public Health, considered that clinical professionals were, and probably are, "the natural managers", "They should be encouraged to be so." However, he felt that, "It is not just doctors, there is a place for other professional groups" (Director of Public Health). The nursing profession, he felt, has had its place in the past, but he considered it had lost its footing and is now trying hard to recover.

A Chief Executive considered that the natural managers were the ones who actually come to the fore, and they could be doctors or they could be others. He rejected the view that owning a medical qualification or an MBA makes someone any more the natural manager. Instead, he argued, it is circumstance, good fortune and so on. He said, "In this hospital there are no natural managers who are doctors at the moment. They would not be interested." He did not believe that any professional group is any more "the natural manager" than any other group.

A similar view was that:

"Many other professions can put up different people, our Head of Training here is an ex Health Visitor for example, down South I did a lot of assessing for GMTS 2 (General Management Training Scheme 2) and I was amazed at the number of Speech Therapists coming through, very competent people. So I don't think there is any particular group, but I would hate to see us go down the line of, like some countries, like in Australia when I was out there looking at the system. To be a Chief Executive out there you had to be a doctor, I don't think that automatically follows."

(Chief Executive, 3)

A retired consultant said that:

"I would say that doctors, consultants have always been the natural leaders of medicine. They are the ones who do the researching, whether it be researching in thoughts or researching techniques on the ground. They bring all the developments forward, they say what is needed, how it is obtained is perhaps another matter, but if you left it for somebody else the developments would slow down. They are the natural leaders of medicine and always have been. Whether this means they are the "natural managers" is another matter."

(Retired Consultant)

Views in favour of doctors being regarded as the natural managers were expressed by informants from the clinical and non clinical professions.

"The ideal manager is the consultant physician who is still involved in patient care."

(NHS Executive Senior Official).

One Clinical Director focused on clinical initiatives and argued that in this context doctors are "the natural managers," but not all doctors are necessarily good managers:

"Where are these initiatives to come from in the clinical field if not from doctors, who else can put forward these initiatives? You would expect doctors to be "the natural managers" in this sense. But the doctor must also have the leadership skills to go along with these initiatives. Everyone can't be a manager. If you have a doctor with a good clinical background, a good doctor who is also a good leader, and not all of them are, then it fits, it clicks."

(Consultant Paediatrician, Clinical Director)

Some informants raised the point that consultant medical staff were more identified with the organisation than Chief Executives and other general managers since they tended to stay in post longer. The more stable identification with the organisation is an important point. The more itinerant lay Chief Executive spends a relatively short period of time in that position, on average about five or six years. This is a short time when viewed against the long term decisions that he/she will be making. In contrast the medical consultant manager usually spends the rest of his working life in the same hospital so perhaps identifies more with the long term strategic decisions and certainly is likely to have to reap the consequences!

A Director of Primary Care thought that Griffiths was right in thinking that doctors are, or could be, "the natural managers", but they were surprisingly absent from some of the positions of power. He said that:

"Relatively few doctors are Chief Executives, this might change but I would have expected to see more doctors at this level by now."

(Director, Primary Care)

Another view, this time from a Director of Purchasing was that:

"Yes I would agree with Griffiths, but only on the basis of them being prepared to accept the running of the service which can never be just wishful thinking and "wouldn't it be better if we could do all these things?" It must be taking on all the challenges and responsibilities and many do. The ones who get involved certainly do, absolutely."

(Director of Purchasing)

One Chief of Service said:

"Doctors are the only ones who can put forward clinical initiatives and change clinical practice. This is an area that I find frustrating. The problem is that even when the doctor is the manager and can point to changes that are likely to happen in clinical practice which may have a huge financial implication, it doesn't mean to say that resources will follow this. But now as managers we have more say, things are changing."

(Consultant Physician (1) Chief of Service)

The analysis suggests that from a clinical point of

view, doctors predictably emerge as the natural leaders of medicine, they are the most professionally developed group in the NHS, they are the ones who conduct the medical research, they bring forward the initiatives, the new medical developments in the clinical field which are crucial in the functioning of the NHS. However, whilst they lead in this respect, the overall question as to whether or not doctors are "the natural managers" remains a matter of debate.

In the next and final chapter I shall summarise my findings and attempt to draw conclusions to the overall research question. The implications of these conclusions will also be discussed.

CHAPTER TEN

CONCLUSIONS

This study has explored the evolving role of NHS doctors in management, together with an attempt, based on fieldwork research, to explore how doctors have recently moved into management and the idea that they are "the natural managers." Also, the associated research question of how important it is for the power and authority of medical staff and lay managers to be brought together to make better use of clinical and other resources in providing health care has been discussed and developed throughout the study.

In the light of the substantive and empirical findings in the thesis, including the responses of my interviewees the following represents my conclusions to these questions and to the questions which emerged from the wider academic debate in the "problematic" chapter four.

There is increasing evidence to support the view that alternative discourses such as those which Fox and others have identified (see chapter 4, pp141-143: p172) in the context of a postmodern perspective are challenging the meta-narrative of the medical model of care (see p172). Managers, especially doctor managers, with their alternative source of authority deriving from their financial, management and health economics discourses, (see p173) backed by government guidelines on priorities and strict financial controls as described in chapter 4 (see p164) pose a more effective challenge to consultant power. In addition, the way government policy is shifting from health care to health, with initiatives such as "The Health of the Nation" (Department of Health, 1991) and "Our Healthier Nation" which were discussed in chapter three (see pp118-123), together with the appointment of the first ever Minister for Public Health (see pp121-122) with a much greater emphasis on health promotion (see pp122-123), and the enhanced position of primary care (see chapter 5) relative to secondary care, especially acute hospital care, show how the government (not the medical profession) is now determining health priorities thus placing hospital consultants in a less central role and therefore questioning the grand narrative on which consultant power was based.

The "maturity of citizens" (see p173) identified in the fieldwork (see pp275-276) is also a challenge to the "taken for granted" notion of the supremacy of consultant power. Increasingly, individual citizens are questioning treatment and care issues as shifts in government policy move away from the medical model of care and encourages citizens to exercise more surveillance over their own health (Foucault, 1980, p155) (see pp140-141) thus reversing the trend to medicalisation of people's lives so condemned by writers such as Illich (1976) and McKeown (1976). As stated by Annandale, Foucauldian social reconstructionism "privileges social over scientific claims to knowledge" (Annandale, 1998, p37). The increased accountability which is being demanded by the public in relation to the inadequacies of medical profession self governance (Salter, 1999) (see pp170-171) is another example demonstrating that present day social and moral conditions are changing and that the dominant rationality of consultant supremacy is being challenged by society.

The changes which are occurring in health services and which have been identified in this thesis, encourage a fresh look to be taken at the "domain theory" analysis of power in health services (see p174) as put forward by Alford and others (see chapter 4). There is an increasing overlap in the structural interest groups with,

for example, doctor managers now occupying both the dominant and challenging interest groups. Lay managers on the other hand are "trespassing" into the professional domain with their new responsibilities for clinical governance. Also the "repressed" community interest group is emerging from its hitherto subservient position suggesting that a "hidden" domain of consumer/user power is now coming forward which may well force the other domains to look at their respective positions. The introduction of The Patients Charter in 1992 which was discussed in chapter 3 (see p123-125) has, in the opinion of Hunter, "added impetus to moves to attach greater importance to consumer views" (Hunter, 1994, p7). In the charter, citizens have to be given "detailed information on local services, including quality standards and maximum waiting times" (Department of Health, 1991a, p10). In addition, purchasers are now expected to involve users more actively over priorities and strategies to improve health (Hunter, 1994, p7). At the same time, one group within the professional domain (i.e. GPs) are also being given more responsibilities and power in relation to the services to be provided by their consultant colleagues. These changes suggest that shifts in power between and within the domains is occurring.

However, whilst the challenges to medical supremacy

outlined above are gathering momentum, they must be viewed against the considerable ability of the medical profession to "neutralise attempts by government and managers to control them...even if part of the strategy of resistance involves adopting the trappings of corporatism" (Hunter, 1994, p20).

With regard to my associated research question relating to the perceived importance of bringing medical and managerial power and authority together, I would argue that this manifests itself in the clinical directorate system which was discussed in chapter 6. The appointment of Medical and Clinical Directors (see pp233: 240:273) in this system together with clinical audit (see pp288-292) is shifting the balance of power from individual consultants to the collectivity of doctors (see pp107: 173: 292). The respondents suggest that the desirability of the union of medical and managerial power and authority is validated in the way doctor managers in this system have used their new found powers to challenge individual consultant resource use (see p267), adopt a more equitable distribution of resources (see p267), make changes (which may be unpopular with consultant colleagues) (see p269) which are of advantage to patients, and to take a broader view of issues (see p370-373). The evidence in this thesis (see chapters 7-9) supports the view that at least

some doctors who have become managers, either as Medical or Clinical Directors, have taken up these new positions with a high level of enthusiasm and have accepted the accountability and responsibility inherent in these posts (see pp278: 338-339). It also shows the extent of doctor manager involvement in difficult managerial areas which often put them at variance with their consultant colleagues (see p379). Doctor managers are also able to make use of greater persuasive powers in relation to fellow doctors than lay managers can generally achieve. For example, whilst my fieldwork data suggests that clinical freedom remains largely intact, (see pp280-288) there was evidence to conclude that a much more limited use of the term "clinical freedom" was made by individual consultants in their discussions with doctor managers (see pp173: 280-288). The fieldwork also suggests (see p296) that there is a willingness amongst doctor managers to work towards the corporate objectives of the Trust even though this may not always enhance the local position of doctors. Their managerial decision making reflects this including a willingness to participate in the difficult area of disciplinary action affecting consultant colleagues (see p269).

Whether the acceptance by doctors of managerial responsibility and accountability, as evidenced in the

fieldwork chapters (see chapters 7-9) amounts to control by "incorporation" (Annandale, 1998, p238) (see p168-169) or whether it is a subtle move by the collectivity of doctors to consolidate the power position (see p173) of the medical profession in the face of mounting challenges to their supremacy is still a matter of debate. In this respect, the views of Marnoch (1996) which were discussed in chapter six (see p259) are important. He considers that becoming the implementors of finance-based controls may well be the price the medical profession has decided it must pay to maintain control of medical standards, education and socialisation (Marnoch, 1996, p119) thus preventing non medical control and preserving consultant power. It may well be that this is now in a different form i.e. collectively rather than on an individual basis. My fieldwork suggests that this is certainly one of the motivations for doctors to be involved in management.

In relation to the core question in this thesis of whether or not doctors are, in Griffiths' terms, "the natural managers", (Griffiths, 1983, p19) there were a number of divergent views amongst respondents, as revealed in chapter nine, with no one professional group emerging as the agreed "natural managers." Some informants considered doctors were "the natural managers" others were equally convinced they were not. The latter comprises

two groups, those who say they tend not to be good managers and those who say that it all depends on the individual or that you need a mix of backgrounds in a management team.

My overall conclusion therefore to this question is that doctors are not necessarily "the natural managers." According to my research findings, the majority of doctors who wish to be involved in management do not see themselves as such. The evidence in the fieldwork supports the view that their managerial aspirations are very much secondary to their clinical interests, typified by this reply from a Clinical Director respondent, "I want to be a part-time doctor manager but I also wish to spend the majority of my time working in the clinical field as a consultant" (see p379). Of some significance was the fact that there was no great queue of doctors waiting to take on these doctor manager positions as evidenced in the succession debate in chapter 9 (see pp354-358). Part of the reason why doctors wish to spend the bulk of their time in the clinical field may relate to the ethical dilemma which involvement in management poses for doctors. This was discussed in chapter six (see p257). Their professional values, motivation and training require them to do whatever is best medically for their individual patients rather than for groups of patients (Hunter, 1994,

p11) which participation in management entails. However, if they do not participate they risk external controls concerning clinical activity being imposed over them (Hunter, 1994, p11).

Their involvement and interest in management is real, they have shown themselves prepared to take on the responsibilities associated with it but primarily they wish to retain their clinical skills and to spend the bulk of their time in the clinical field; indeed in order to retain the support of their clinical colleagues it is necessary for them to do so. Their appointment in management positions is almost always temporary and part-time, they have to be part clinician, part manager. None of the doctor managers I interviewed aspired to "going it alone" or managing the whole of the organisation. They did not see themselves as "the natural managers", in the hierarchical sense, as one individual "in charge." Instead, they expressed a strong desire to work in partnership, (using the Clinical Directorate system as the vehicle to enable them to do so) (see p272-273) to bring their power to the management process and to work with lay management and other health professionals to bring about improvements to patient

services and to further the quest to obtain better value for money in the services provided.

A significant finding in the fieldwork (see p319: pp327-328) was the limited control Chief Executives still have over consultant medical staff, especially on clinical matters. In the late 1980s, Harrison, (see chapter 4 p146) concluded that "The prime determinant of the pattern of the health services is still, just as before Griffiths, what doctors choose to do" (Harrison, 1988, p123). My fieldwork would confirm that this is still largely the case (see p319). Griffiths' idea of one person in overall charge did not seem to have been realised so far as consultant medical staff were concerned. The financial and managerial discourses (see p172) which were discussed earlier in this chapter (see p387) and in chapter 4 (see pp143-144) are having an effect but in the main lay managers continue to struggle to exert any real managerial control over doctors, especially doctor managers.

One possibility to be explored in relation to this flaw in the management structure could be to have a shared partnership in decision making at the top of the management structure between the (generally) lay Chief Executive and the part time senior doctor manager who

continues to practice and who thus still has the support of his/her consultant colleagues. Whilst doctors do not see themselves as "the natural managers" they are receptive to the idea of a shared dialogue in decision making provided they are allowed to spend the majority of their time in the clinical field. The senior doctor manager already has a statutory position on the Trust Board so already has considerable influence over medical staff. The implications of this dual leadership would mean more shared operational and strategic decision making which could well be of considerable benefit to the organisation, including tackling inefficient clinical practice issues where these exist (see p272) changes which hitherto have been impossible to tackle with any degree of success.

During my research, which took me to hospitals and other health service organisations, I found evidence in my fieldwork (see pp313-314: 347-349) of a re-emergence of a limited degree of consensus management with doctor managers, GPs, and lay managers all being key players in the future operation of health services. Griffiths argued against the consensus style of management which was subsequently discarded by the NHS. However, in reality few decisions are taken in isolation, each decision must

involve dialogue between the parties to the decision. At operational level, these parties are now more likely to be the doctor manager and the lay manager with distinct advantages for both, and hopefully, for the better use of resources, not least clinical resources. Doctors reflected a strong view that medical knowledge and expertise needed an influential, even (dominant) voice, which they could bring. However a shared leadership could perhaps provide the balancing factor designed to protect against the risks of medical (or management) interests becoming too dominant.

In secondary care, with which this thesis has been mainly concerned, the evolving role of doctors in management, albeit usually on a part time temporary basis, has led to a position where the considerable talents of doctors are now being utilised in the management process in ways which actually and potentially benefit the organisation. A Chief Executive respondent (see p364) suggests that they bring a freshness of approach and a new dimension to the management process which has paved the way for the next generation of doctors in management. Trust Boards need to encourage and develop this in order to bring about the enormous benefits that such involvement can produce. They would do well to make this one of their high priorities which, in addition to reaping the

benefits, may also help to overcome the present quite fragile involvement of doctors in the formal management process as evidenced in the succession debate (see chapter nine, pp354-358). The succession problems are not theoretical, they are real and need to be addressed by Trust Boards, especially as most doctors take on management positions on a rotational basis.

For future research, it will be fascinating to see how doctors in management respond to the effects of further radical changes taking place now or about to take place in the NHS. Although the effects of these changes are outside the time scale of this study, they are, in the words of a health authority official, "shifting the ground beneath my feet" (Jarrold, 1998). Initiatives such as clinical governance, with the establishment of the National Institute for Clinical Excellence; how the Commission for Health Improvement sets about its tasks to conduct national and local reviews on the implementation of the NICE guidelines and how it reviews quality arrangements and identifies and tackles serious or persistent clinical problems; the development of the primary care groups and the new management role for GPs in these groups; how the problem of succession unfolds in secondary care; the effects of the explosion in

information technology; how evidence based medicine develops; the effects of NHS Direct and whether it changes the relationship between patients in the community and the NHS, or acts as a gatekeeper to primary care; the long-term effects of the PFI...but these are all parts of another story, another chapter in the evolving story of the role of doctors in management.

INTERVIEW SCHEDULE
QUESTIONS TO ALL RESPONDENTS

- 1) What, in your opinion are the key tasks for NHS managers?
- 2) What does management require? What personal characteristics/what powers?
- 3) Respect, Credibility. How does a manager acquire these?
- 4) Does it make any difference whether managers are doctors, lay managers, other professionals?
If so, why?
If not, why not?
- 5) Do you think clinical knowledge, is an essential ingredient in the management of the NHS?
If so, why?
If not, why not?
- 6) What, in your view have been the major changes in NHS management since the 1970s?

- 7) In your view which changes have had the major impact?
- 8) In your view has the medical profession become more, or less involved, in the management of the NHS?
In what way? Informally? Formally?
If more involved, in what ways?
If less involved, explain
- 9) Do you think doctors should be more actively in the management of the NHS?
If so, why?
If not, why not?
- 10) Do you think the government wants doctors to be more actively involved in management?
If so, why?
If not, why not?
- 11) What are the implications of this involvement?
- 12) Is it a waste of, in many instances, a scarce clinical resource, for the doctor to be actively involved in management?

- 13) If more importance is given to the role of the doctor in management, how far does this outweigh the reduction of the face to face clinical role?
- 14) Do you think clinical autonomy/clinical freedom has been reduced in the last decade?
If so why? What are the implications of this?
If not, explain
- 15) Has the balance of power shifted between doctors and lay managers? Between doctors and other health professionals, between doctors and their employers, between individual doctors and the medical profession? If so, in what way?
- 17) Which model of management ie doctor manager, GP manager, lay manager, other NHS professional manager, do you think is best suited to trying to preserve the basic principles of the NHS, yet be realistic about scarce financial and other resources?
- 18) Relationships. To be an effective manager, how important are professional relationships? How can these relationships be developed?

- 19) How do you see the involvement of doctors in Chief Executive positions/General Management roles in the future?
- 20) How do you think the role of the NHS doctor in management has evolved over the years?
- 21) Who do you regard as the "the natural managers" of the NHS?
Why?

ADDITIONAL QUESTIONS TO DOCTOR MANAGERS

- 1) What do you see the role of the Clinical Director to be?
- 2) What do you think are the main obstacles to him/her fulfilling this role well?
- 3) What special training do you think a Clinical Director needs to carry out these tasks?
- 4) What proportion of time should a Clinical Director be appointed to and why? - Part time X sessions per week?
- 5) What should be the duration of appointment ie 3yrs, or 5yrs or longer?
- 6) Use of Resources. Does the Clinical Director have a real say in the use of the following resources?
 - i) Staff: Setting and changing establishments
Selection of key staff.
 - ii) Financial: Are you included in budgetary allocation discussions prior to the budget being set?

iii) Planning: Capital allocations etc

iv) Other Resources:

- 7) Decision Making. How far is this devolved to the Clinical Director? Do you think decision making powers for doctors in management are real?
- 8) At Clinical Directorate meetings, what are the most common agenda items? Who attends these meetings? Is the Chief Executive sometimes invited? What is the distribution of the minutes? Is there a follow up mechanism to ensure decisions reached are implemented?
- 9) Membership of committees. Which committees are the Clinical Directors on which you consider to have real influence?
- 10) What are the main political difficulties facing the Clinical Director? Local? National?
- 11) What qualities do you think a Clinical Director needs to have?
- 12) After a period as a Clinical Director, what next? Does the time spent as a Clinical Director prepare

the doctor for higher management ie Chief Executive positions?

- 13) How do you think, those doctors who have become managers, have behaved in their new role? Do they see the wider implications of decisions, both clinical and non clinical, and the wider use of resources which a manager is required to consider?
- 14) What are the advantages/disadvantages of being a Clinical Director?
- 15) What are the main attractions for doctors to become more actively involved in management?
- 16) Do you think the Medical/Clinical Directorate systems provide the NHS with the solutions to its long standing management problems?

ADDITIONAL QUESTIONS TO TRUST CHIEF EXECUTIVES

- 1) What do you see the role of the Clinical Director to be?
- 2) What special training do you think a Clinical Director needs to carry out these tasks?
- 3) What do you think are the main obstacles to him/her fulfilling this role well?
- 4) What proportion of time should a Clinical Director be appointed to and why? - Part time X sessions per week?
- 5) What should be the duration of appointment ie 3yrs, or 5yrs or longer?
- 6) What qualities do you think a Clinical Director needs to have?
- 7) How do you think, those doctors who have become managers, have behaved in their new role? Do they see the wider implications of decisions, both clinical and non clinical, and the wider use of resources which a manager is required to consider?
- 8) Is it possible to have a copy of your management structure, in particular as it applies to medical staff in management, together with copies of job descriptions for Medical/Clinical Directors?

ADDITIONAL QUESTIONS TO GENERAL MEDICAL PRACTITIONERS

- 1) How has the management role for GPs in practices altered over the years? How far and in what ways have GPs managed their practices? (ie prior to the reforms and after the reforms)

- 2) What has been the major impact of the 1991 NHS Reforms on the management of GP practices?

- 3) Has the GP's role as manager increased? If so, what are the implications of this? For patients, for the practice, for GPs? If not, explain.

- 4) What committees are GPs now involved in outside the practice? Health Authorities, Trust Boards etc?

- 5) Are you involved on any of the committees or boards you think make the important decisions in the NHS? If so, which ones?

- 6) Has the shift in emphasis from Hospital to Primary Care affected the management of GP practices? If so, how? If not, explain.

Appendix II

Specimen copy of letter sent to key informants
requesting an interview

22, Barley Mill Road
Consett,
Co. Durham.
DH8 8JP

Telephone: 01207 501858

12th June 1996

Dear

I am currently undertaking post graduate research for a PhD at the University of Durham, researching organisation and management in the National Health Service over its first 50 years of operation.

I have a particular interest in the evolving role of NHS doctors in management over this period and I write to ask if you would be kind enough to allow me to come and see you and have a short discussion in this connection. I attach a list of the areas of discussion I have in mind.

I shall of course observe strict anonymity in the information I obtain, I shall not be including any names or any other means of identifying the key people I interview.

A little information about myself, I have completed my career in the National Health Service as a District General Hospital Manager in the North of England. I recently studied for and obtained a Masters Degree in Health Services Studies at the Nuffield Institute for Health at the University of Leeds and I am now entering my third year of PhD study at the University of Durham.

My thesis Supervisor is Doctor Jane Keithley, a lecturer in Social Policy at Durham University and Chairperson of Community Health Care, North Durham NHS Trust, who would be happy to verify the information I have included in this letter. Dr Keithley's telephone number at the University of Durham is 0191 374 4730.

I should like to thank you in anticipation of your help in this matter, and, if you are able to see me, I shall look forward to meeting you, at your convenience, in the near future.

Unless I hear from you to the contrary I shall contact you by telephone during the next week or two to try and arrange a date and time to meet.

Yours sincerely,

Mr F.J. Wall BA MA MHSM

Appendix III

Occupational Categories of Key Informants Interviewed

DOCTOR-MANAGERS

Chief of Clinical Services, Medical Director
Consultant Physician (1) Male) Named as "Medical
Medical Directors) Directors, Consultant
Consultant Physicians (2) Male) Physicians" 1,2 or 3 in text
Consultant Psychiatrist (1) Female

Clinical Directors

Consultant Anaesthetists (1) Male
Consultant Histologist (1) Male
Consultant Paediatrician (1) Male
Consultant Obstetrician and Gynaecologist (1) Male

Consultant Anaesthetist (1) Female

General Medical Practitioner (1) Male

Senior NHS Executive Official (1) Male

Director of Primary Care (1) Male

Director of Public Health (1) Male

Consultant Physician (1) Male

LAY-MANAGERS

Chief Executives (6) Male (named as Chief Executive
1,2,3,4,5, or 6 in text)

Director of Purchasing (1) Male

GP Practice Manager (1) Female

Community Health Council Chief Officer (1) Male

Senior Organisation and Development Manager (1) Female

Locality Manager (1) Female

NURSE-MANAGERS

Senior Nurse Managers (2) Female (named as "Senior Nurse
Manager" 1 or 2 in text)

ACADEMICS

Senior Research Fellow (1) Female

Senior Fellow (1) Male

OTHERS

Retired Consultant, former Health Authority member (1) Male

Appendix IV

Organisations visited for the purpose of carrying out fieldwork and conducting research interviews

Bishop Auckland Acute Hospital NHS Trust

British Association of Medical Managers Headquarters
Barnes Hospital, Cheadle, Cheshire

Community Health Care North Durham NHS Trust

County Durham Health Authority

County Durham Research and Development Alliance

Darlington Memorial Acute Hospital NHS Trust

General Medical Practitioner Surgeries in Northumberland
and County Durham.

Health Economics Consortium, University of York.

Newcastle and North Tyneside Health Authority

NHS Executive, Northern and Yorkshire Region, John Snow
House, Durham

North Durham Acute Hospitals NHS Trust, Dryburn Hospital,
Durham

North Durham Acute Hospitals NHS Trust, Shotley Bridge
Hospital

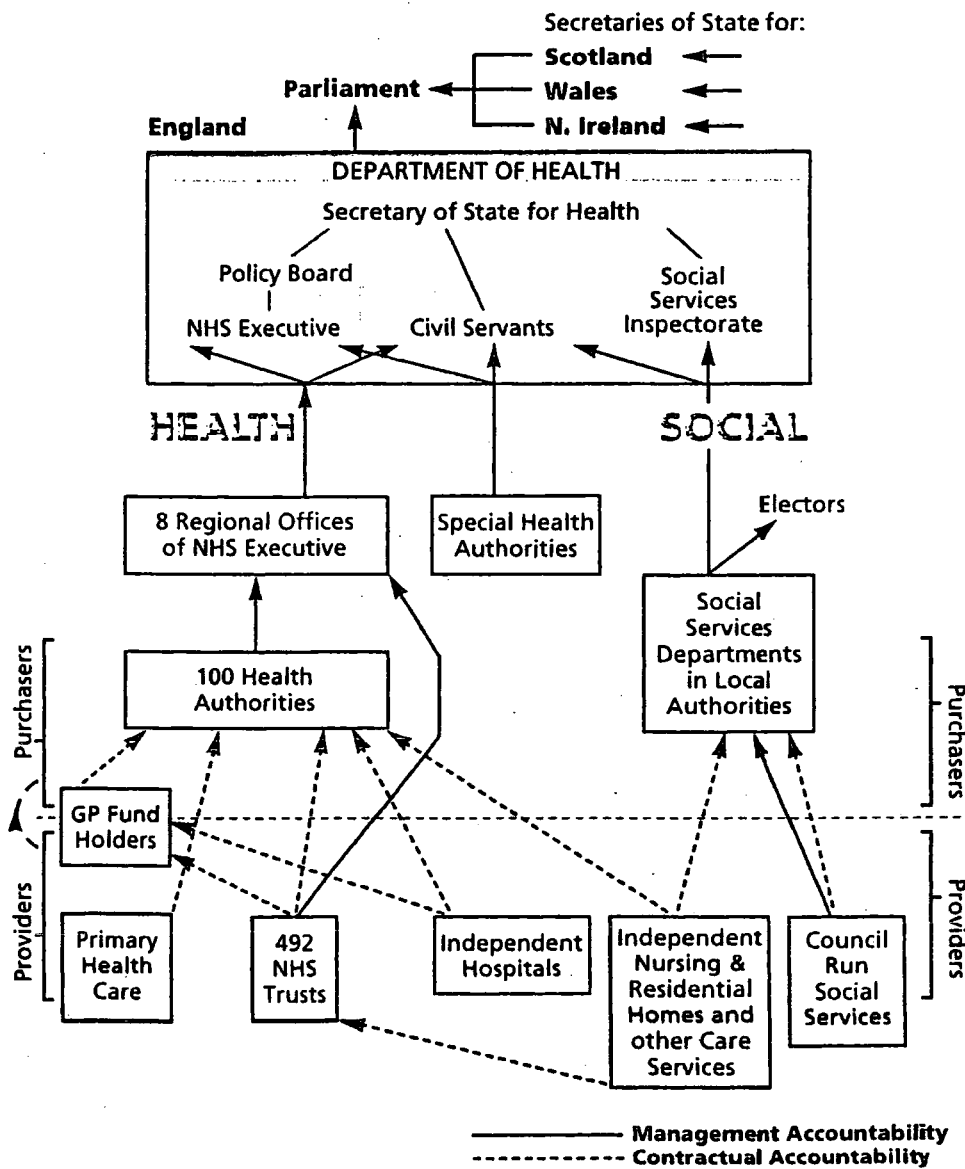
North Tees Acute Hospitals NHS Trust

South Tees Acute Hospitals NHS Trust

South Tyneside Acute Hospital NHS Trust

University of Durham, Department of Health Studies

THE STRUCTURE OF HEALTH
AND
SOCIAL SERVICE PROVISION
(Post 1996)



Source: Health Service Journal (1997)p4

TRADITIONAL HOSPITAL ORGANISATION STRUCTURE
(MSC = Medical Staff Committee)

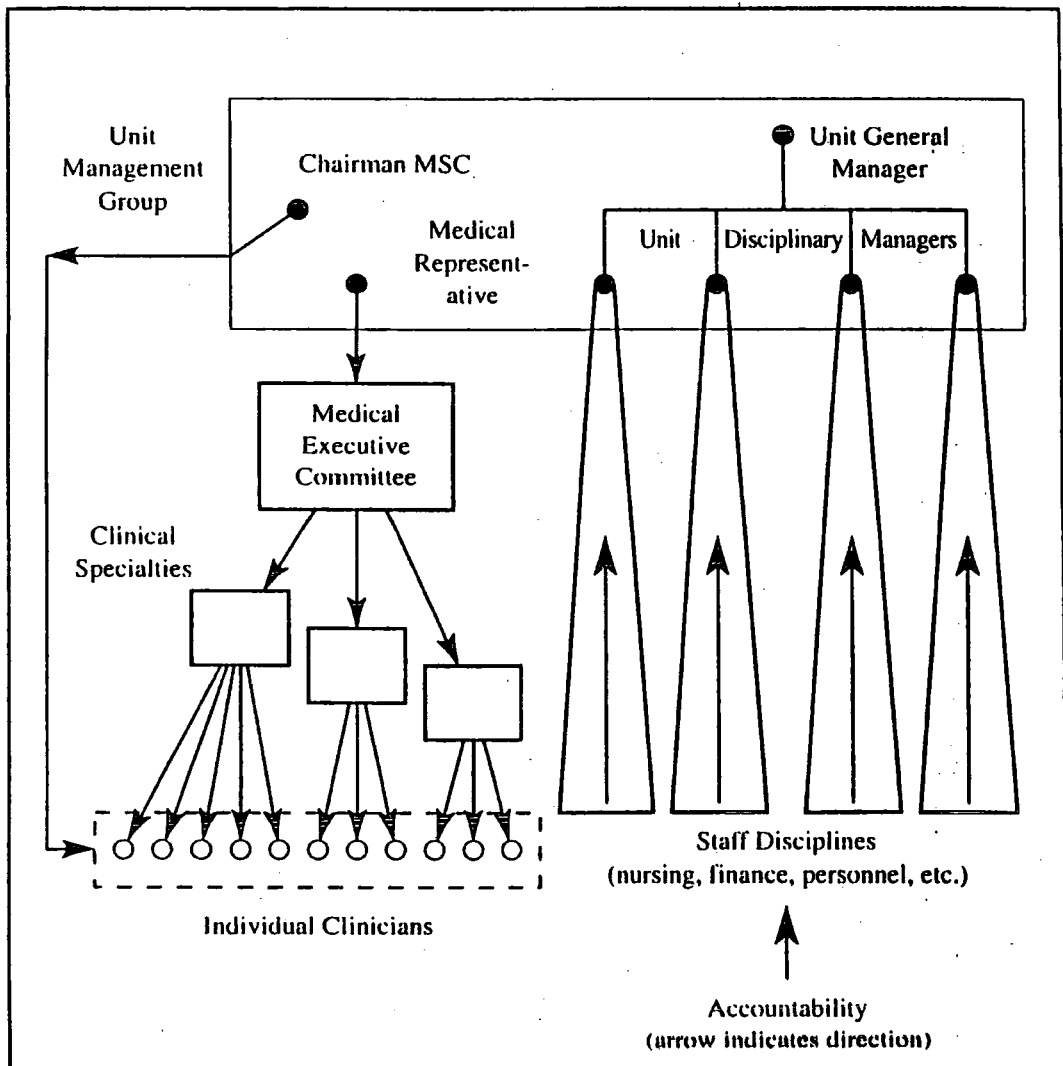


Figure 6 (1)

Source: T Packwood et al (1992) "Process and structure: resource management and the development of sub-unit organisational structure" *Health Services Management Research*, 5 (1) Cited in Harrison and Pollitt, (1994), P88)

Appendix VII

**CLINICAL DIRECTORATES IN THE NHS:
A TYPICAL STRUCTURE**

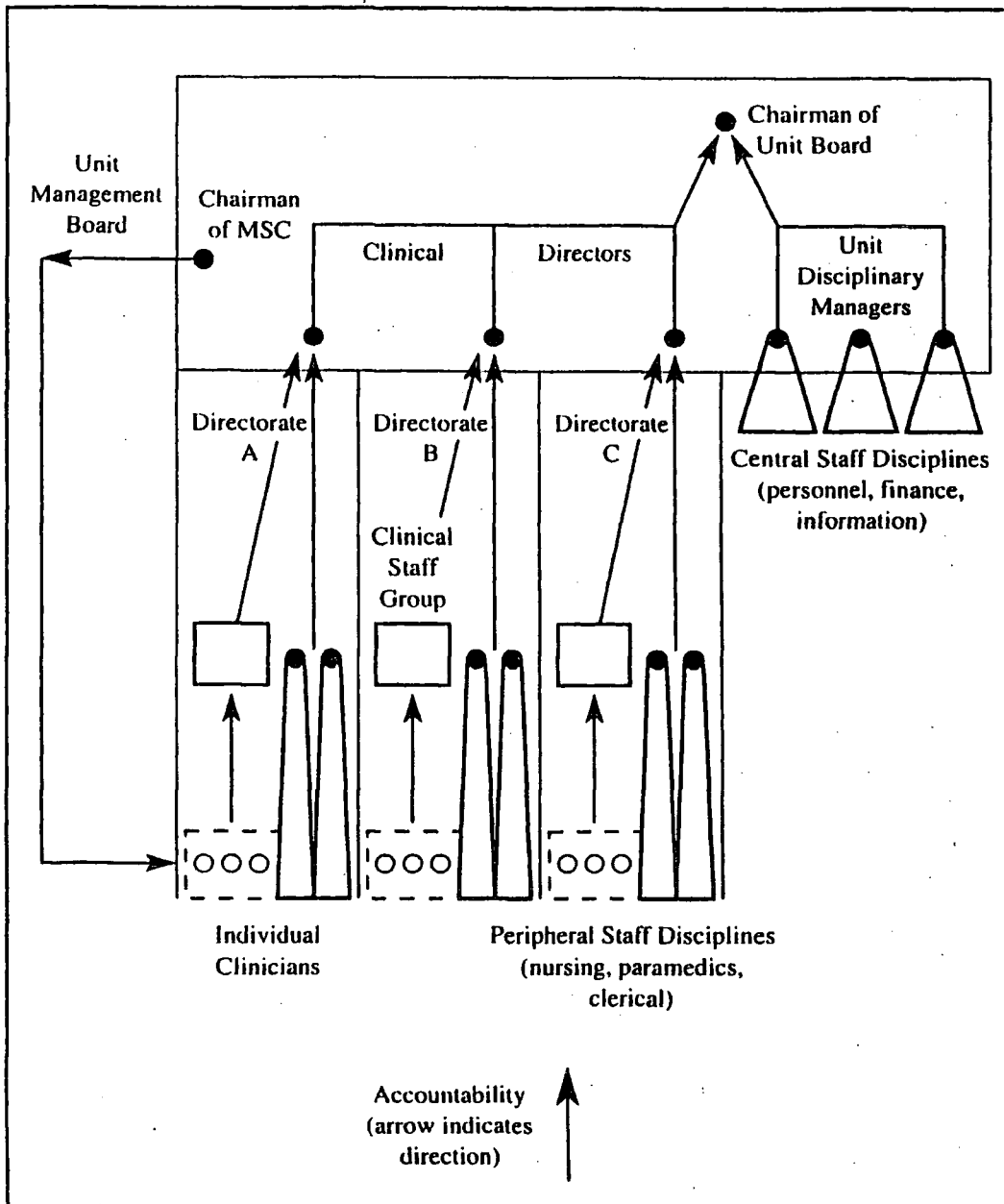


Figure 6 (2)
 Source: T Packwood et al (1992) "Process and structure: resource management and the development of sub-unit organisational structure" Health Services Management Research, 5 (1) Cited in Harrison and Pollitt, (1994), P91)

J O B D E S C R I P T I O N

Medical Director

1. SUMMARY

The Medical Director is a Board Director and has responsibility for developing the comprehensive provision of medical services and for advising how these contribute to the aims and priorities of the Trust.

2. ACCOUNTABILITY

Accountable to the Board of Directors.

3. KEY RESPONSIBILITIES

(a) Medical Services

- To advise on arrangements for ensuring that the general performance of medical services in all specialties is efficient and in line with current medical practice.
- To review existing medical services, identifying any shortfalls in the range of services provided and to propose ways of dealing with them.
- To develop and facilitate the participation of Consultants in management.
- To establish arrangements for obtaining medical opinions on priorities for development (or retrenchment) and ensure that these priorities are consistent with financial and other considerations.

(b) Contracts of Service

- To facilitate and coordinate the identification of new and changing areas of need relevant to the Trust's services.
- To represent the developed views of the Trust to potential purchasers.

- To develop methods for reviewing the outcomes of medical services and their impact on need in the population.
- To develop an appropriate public relations profile concerning the ability of the Trust to respond to local needs.
- To assist in the development of quality measures to be incorporated within contracts.
- To develop workload agreements with consultant staff.
- To pursue a Trust approach to the management of waiting lists with consultant staff.

(c) Medical Education

- To ensure medical education is integrated with the Trust's services.
- To ensure activities of those involved in postgraduate education - clinical tutors, postgraduate and clinical deans and the Royal Colleges - are coordinated with the aims of the Trust.

(d) Clinical Research

- To advise the Trust on how research contributes to its aims and priorities.
- To develop and maintain links with the University and other appropriate bodies.
- To develop policies which facilitate clinical research and to identify research priorities.

(e) General Practitioners

- To facilitate and encourage good relationships between the Trust and 'General Practice.'

(f) Medical Audit

- To assist the development of the Medical Audit process.
- To assist in the auditing of clinical data.

(g) Information Technology

- To advise on priorities for the development and implementation of clinical

computer systems.

- To advise on information needs of consultant and other medical staff.
- To assist in the implementation of the 'case-mix' system.
- To ensure IT policies are appropriate to clinical needs.
- To participate in the development and promote the up-take of Information Management Technology training programmes for clinical staff.
- To develop a training strategy for IMT related issues.

(h) Medical Records

- To advise on the appropriate delivery of medical records services across the Trust.

(i) Medical Staff

- The Medical Director will be a member of all Advisory Appointments Committees.
- The Medical Director will agree and review job plans with Consultants.
- To advise on, and participate in, induction and non-clinical training programmes for junior doctors.
- To assist in the development of induction programmes for consultant staff.

4. TERMS AND CONDITIONS OF SERVICE

- National Terms and Conditions of Service for Hospital Medical and Dental Staff will apply.
- Precise salary will be negotiable with the Chief Executive.
- The appointment is for an initial three year period.
- Full secretarial services will be provided and office accommodation will be provided.

JOB DESCRIPTION

JOB TITLE : CHIEF OF SERVICE
UNIT :
ACCOUNTABLE TO : CHIEF EXECUTIVE
ACCOUNTABLE FOR : DIVISIONAL MANAGER
MANAGERIAL PERFORMANCE OF CLINICAL DIRECTORS

JOB PURPOSE

To develop, in conjunction with the consultant medical staff, Clinical Directors and Divisional Manager, a comprehensive range of specialties. To ensure that the human, financial and physical resources available to the Division are used for the optimal benefit of patient care and treatment outcome.

KEY RESULT AREAS

- (a) Develop realistic, achievable but ambitious business plans that contain the forward plans of the specialties within the Division.
- (b) Ensure that the ethos of the Division is based upon a commitment to quality in everything it does and that the practices of the Division meet this overall aim.
- (c) Secure the maximum resources available through the contracting mechanisms to meet divisional costs. Ensure that senior clinical staff are involved in and committed to the terms of contracts and that contracts are met in full.
- (d) Achieve effective budgetary control throughout the Division. Hold the budgets for the Division and ensure effective day to day delegation of authority.
- (e) Provide effective leadership so that clear achievable goals are established which have the commitment of the staff of the Division.
- (f) Develop support and promote the role of Clinical Directors and Divisional Manager. Review and monitor their managerial performance.
- (g) Ensure that staff in the Division are encouraged to maximise their potential and are given appropriate training and development opportunities.
- (h) Ensure that information is disseminated quickly and effectively throughout the Division in order that staff are kept informed and involved.
- (i) Make a significant contribution to the overall corporate management of the Unit through membership of the Unit Management Group and other ad hoc committees.

JOB DESCRIPTION

Name :

Post Title : Medical Director

Job Purpose : To create and maintain a team of clinicians providing the highest standards of clinical care achievable within the resources provided.

Dimensions : £100 million

Staff supporting this post :

Consultant in Public Health Medicine -
(Assistant Medical Director) - to be appointed

Risk Manager

Legal Services Manager

Two Personal Assistants

Four Secretarial Staff

Organisational wide responsibility for the management of litigation, complaints, research and development and the recruitment and discipline of senior medical staff.

Four thousand staff, including 125 Consultants, 155 junior medical staff.

**Summary Organisation
Chart :**

Attached

Key Result Areas : To ensure the Trust and other bodies are provided with expert clinical advice;

To provide advice to the Trust on medical staffing issues;

To ensure that complaints are managed such that criticisms and concerns are addressed and whenever possible, appropriate remedial steps taken;

To minimise the cost of litigation, both in terms of money and loss of reputation of the Trust, as a result of acts and omissions of its employees;

To develop a research and development programme within the Trust which supports the medium and long-term objectives of the Trust;

To act as an Executive Director in the resolution of corporate issues;

**Most Challenging
Part of the Job :**

There are few right answers and to each proposal there is generally a negative political response. The challenge is to maintain progress on a number of fronts, such that we move towards an organisation that achieves an ever increasing standard of care. This is in a background of finite resources and at times diminishing resources. The workforce is intelligent, articulate and organised in small professional groups. No role model exist as this posts is in the vanguard.

Medical Director
June 1994

JOB DESCRIPTION
CLINICAL DIRECTOR

ACCOUNTABLE TO : CHIEF OF SERVICE - DIVISION OF (FOR PERFORMANCE
IN RESPECT OF THIS
MANAGERIAL ROLE)

ACCOUNTABLE FOR: STRATEGIC AND BUDGETARY PERFORMANCE OF CLINICAL
MANAGERS

JOB PURPOSE

To develop, in conjunction with the other consultant medical staff, a comprehensive range of effective services. To ensure that the human, financial and physical resources available to the Directorate are used for the optimal benefit of patient care and treatment outcome.

KEY RESULT AREAS

- (a) Develop realistic, achievable but ambitious business plans which outline the forward plans of the specialty.
- (b) Ensure that the ethos of the Directorate is based upon a commitment to quality in everything it does and that the practices of the Directorate meet this overall aim.
- (c) Secure the maximum resources available through the contracting mechanisms to meet Directorate costs. Ensure that senior clinical staff are involved in and committed to the terms of contract and that contracts are met in full.
- (d) Achieve effective budgetary control throughout the Directorate. Manage the budgets for the Directorate and ensure effective day to day delegation of authority.
- (e) Provide effective leadership so that clear achievable goals are established which have the commitment of the staff of the Directorate.
- (f) Review and monitor the performance of the Clinical Manager in conjunction with the Divisional Manager.
- (g) Ensure that staff in the Directorate are encouraged to maximise their potential and are given appropriate training and development opportunity.
- (h) Ensure that information is disseminated quickly and effectively throughout the Directorate in order that staff are kept informed and involved.
- (i) Make a significant contribution to the overall corporate management of the Division.

- JOB DESCRIPTION -

POST : Clinical Director

RESPONSIBLE TO : Chief Executive

AIM OF POST : The Clinical Director is the organisational head of the Directorate and is the prime budget holder, responsible for its strategic and day to day management, and the overall delivery and performance of the Directorate's services.

RESPONSIBILITIES

- To act as the budget holder for the Directorate and to manage within the established financial framework.
- To agree and deliver a Business Plan with the staff of the Directorate and with the management of the Hospital.
- To regularly monitor progress against the Business Plan and expenditure against budget and take any corrective action that may be required.
- To have managerial responsibilities for objective setting and performance appraisal of staff within the Directorate.
- To ensure that the Directorate fully participates in all Hospital wide programmes and initiatives eg staff training and development.
- To ensure that the Directorate adheres to Hospital wide operational and professional policies and ensures their implementation.
- To ensure that the Directorate operates within the established nursing, financial, personnel and information management frameworks.
- To develop good internal communications within the Directorate and with other Directorates so that all proposals and developments which may have implications for the Hospital and for other Directorates can be assessed.
- To establish and maintain a supportive working environment, specifically to foster a sense of Directorate identity and team spirit.

- To report to the Medical Director, together with other Directors, in the development of comprehensive provision of medical services and advise how the Directorate contributes to the aims and priorities of the Hospital.
- To review existing medical services within the Directorate and to identify short-falls and ways in which to deal with them.
- To agree a workload pattern and targets with Consultant colleagues.
- To agree with colleagues the priorities for committing resources.
- To ensure the delivery of agreed targets of professional performance with the Directorate.
- To identify trends in professional practice that offer an opportunity for improvement in standards and to implement these where possible.
- To establish audit.
- To determine the Directorate's annual quality improvement programme.

EDUCATION AND RESEARCH

- To participate in the organisation of Directorate training.
- To create an environment conducive to learning.
- To promote the concept of research and to facilitate research activities within the Directorate.

MENTAL HEALTH DIRECTORATE

CLINICAL DIRECTOR

Job Description

Job Aims

The Clinical Director is responsible for the Leadership, Management and strategic direction of the Directorate in the context of the Trust's strategic aims.

Main Responsibilities

1. Is responsible for the strategic direction of the Directorate in the context of the Trust's corporate strategy and national and Purchaser priorities.
2. To provide leadership and motivation to the Directorate.
3. To manage the Directorate's budget.
4. Formulate, negotiate and implement the Directorate's Business plan.
5. To ensure that all services meet agreed Quality standards including the Mental Health Act 1983, Patients Charter etc.
6. To foster a culture within the Directorate in which Research, Audit and Evidence based practice are valued.
7. To ensure that effective communication systems are in place within the Directorate.
8. To provide direct management to the Directorate's General Manager including an annual appraisal of his/her performance.
9. In relation to Consultant staff within the Directorate: ensure that activity is coordinated within available resources, that job plans are reviewed with individuals and the Medical Director and agree study leave for Career Doctors in accordance with the Trust's CPD committee guidelines.
10. To chair the Directorate Management Team and participate in all relevant Trust wide committees. To act as the main spokesman for the Directorate both within the Trust and externally.
11. To ensure that information is available to monitor activity etc.
12. To ensure the Directorate meets its' commitments in relation to Health and Safety at Work etc.

Working Relationships

The Clinical Director is directly accountable to the Chief Executive for the effective discharge of his/her role and duties as outlined above.

The Clinical Director has ultimate responsibility for the management of all Directorate staff through the General Manager (Mental Health) except for Consultant staff- see section 9 above.

The role of the Clinical Director demands effective liaison and collaborative working with colleagues within the Trust and with external bodies and agencies. The Clinical Director has a key role in this respect.

JOB DESCRIPTION

CLINICAL DIRECTOR

POST: DIRECTOR OF

RESPONSIBLE FOR: Managing the Division of

JOB SUMMARY:

The Clinical Director is responsible for the leadership, management and strategic direction of the Division, ensuring that arrangements exist for the effective and efficient operation of services, within the resources available. He/she delegates day-to-day management to the Divisional Manager. The Clinical Director is a member of the Executive Committee.

MAIN RESPONSIBILITIES:

The principal responsibilities of the post of Clinical Director are based upon the following:-

1. Managing and motivating all staff within the Division, establishing arrangements for the recruitment, training and development of those staff and ensuring they are aware of the values, aims and objectives of the Trust.
2. Formulation, negotiation and implementation of a Divisional Business Plan, which fully matches divisional aspirations to the requirements of purchaser contracts but acknowledges resource limitations.
3. Managing Divisional budgets within the limits and budgetary rules agreed at the beginning of each Financial Year.
4. Organising the work of the Division, chairing Divisional meetings and spokesperson on all Divisional matters and aspirations.
5. Ensuring satisfactory arrangements exist within the Division for managing medical, nursing and multi-disciplinary audit as well as compliance with quality standards and measures within the Quality Assurance Programme.
6. Ensuring that a comprehensive communications network exists within the Division for the speedy and accurate transmission and understanding of corporate and divisional aims and objectives, professional and service standards and general information.

7. The management of change, monitoring and review of divisional activity and performance and ensuring compliance throughout the Division with appropriate professional practices and policies/procedures.
8. Completing an annual formal performance appraisal of the Divisional Manager.

WORKING RELATIONSHIPS:

The Clinical Director is directly accountable to the Chief Executive for effectively discharging the role and responsibilities set out in this document.

The specific organisational relationships of the Clinical Director are:

Manages:-

- (a) All staff employed within the Division:

All NHS employees work within certain limits and constraints. These may be ethical, legal, professional or financial and determined nationally, regionally or locally. Within such limits, staff exercise differing degrees of discretion in making clinical decisions. It is in the exercise of this discretion that a fundamental difference exists between consultants and other clinical staff. For all staff, except consultants, the exercise of this discretion is open to managerial appraisal and direction. Consultant medical staff in making clinical decisions remain clinically autonomous. However, all staff are accountable for the expenditure of all of the resources used in support of a clinical role.

- (b) Liaison:

The role of Clinical Director demands effective liaison and collaborative working of the highest order, in terms of all parts of the local organisation and with external bodies and agencies. The Director has a key role in this respect and through membership of the Executive Committee, makes an important contribution to effective corporate working.

JOB SPECIFICATION:

A Clinical Director must be a consultant member (or equivalent) of the Division, based at

Requirements for the post include a detailed understanding and knowledge of the organisational working of North Tees, its culture and networks. The postholder should demonstrate commitment to the aims and objectives of both the Trust and the Division by the provision of visible leadership. This will require both accessibility and a regular time commitment.

Two paid notional half days per week are formally allocated to these duties, although the nature and demands of the post are such that this may well be exceeded).

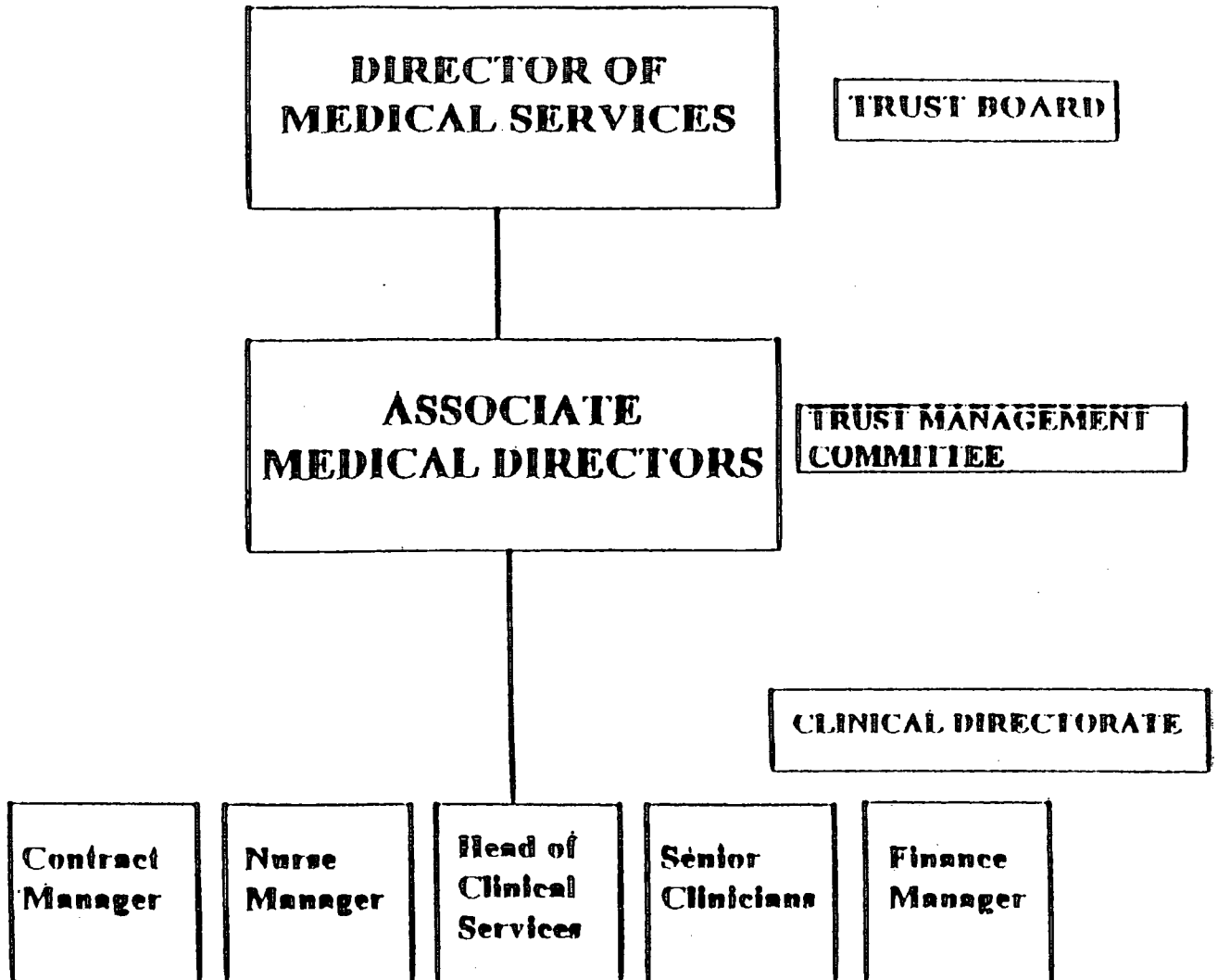
DURATION:

A Clinical Director is elected for a period of three years in accordance with the Procedural Document for Medical Members: Executive Committee and Divisions - September, 1991 and is eligible for re-election for a maximum of a further three years.

ACCOUNTABLE TO: Chief Executive and subject to annual individual performance review

..00000..

A TYPICAL CLINICAL DIRECTORATE MANAGEMENT STRUCTURE



- NOTES**
- 1 ASSOCIATE DIRECTORS MAY ALSO BE HEADS OF CLINICAL SERVICES
 - 2 NURSE MANAGERS MAY ALSO BE CONTRACT MANAGERS
 - 3 NURSE MANAGERS AND FINANCE MANAGERS MAY BE RESPONSIBLE FOR MORE THAN ONE DIRECTORATE

(Source) British Association of Medical Managers (1996a)

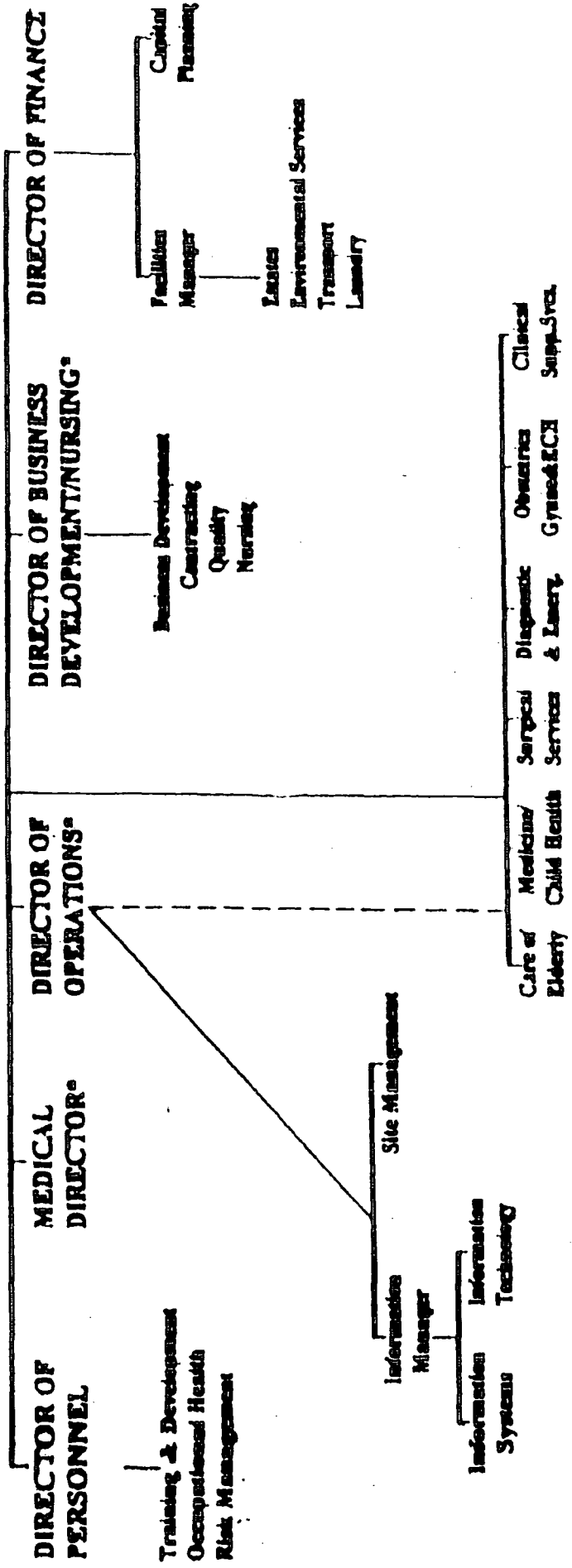
ORGANISATION STRUCTURE

BOARD



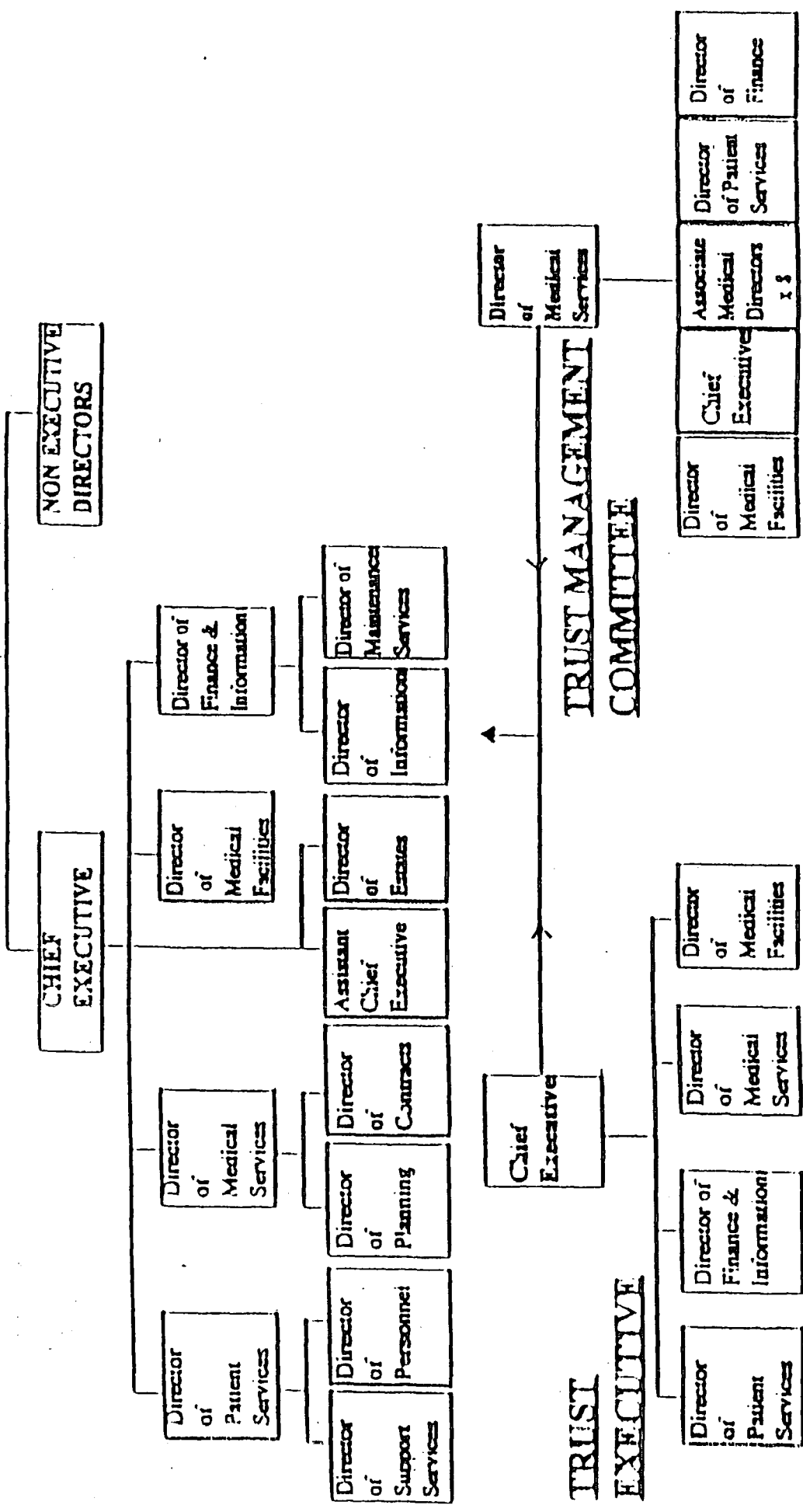
MANAGEMENT EXECUTIVE

CHIEF EXECUTIVE



(*Trans B - ...)

(Source) British Association of Medical Managers (1996a)



(Source) British Association of Medical Managers (1996a)

CLINICAL DIRECTORATES

SURGICAL SERVICES

OBSTETRICS, GYNAECOLOGY & ECH SERVICES

MEDICINE & CHILD HEALTH

CARE OF THE ELDERLY

DIAGNOSTIC & EMERGENCY SERVICES

CLINICAL SUPPORT SERVICES

Clinical Director

Clinical Director

Clinical Director

Clinical Director

Clinical Director

Clinical Director

Anaesthesia
 Elmstead Day
 ENT Surgery
 General Surgery
 Intensive Care
 Pain Clinic
 Plastic Surgery
 Trauma &
 Orthopaedic Surgery

Community Midwifery
 Family Planning
 GP Maternity Units
 Obstetrics & Gynaecology
 Oncology
 Nuclear Medicine
 Medical Physics
 Ophthalmology
 Optometry
 Orthotics
 Oral Surgery
 Orthodontics
 Psychology

Chest Medicine
 Clinical Haematology
 Community Dental
 Coronary Care
 Physiological Measurement
 Diabetic Services
 General Medicine
 GU Medicine
 Health Visiting
 School Nursing
 Neurology
 Neuro-Rehabilitation
 Paediatrics
 Rheumatology & Rehabilitation
 Thoracic Medicine
 Dermatology

Emergency Pathology
 Radiology

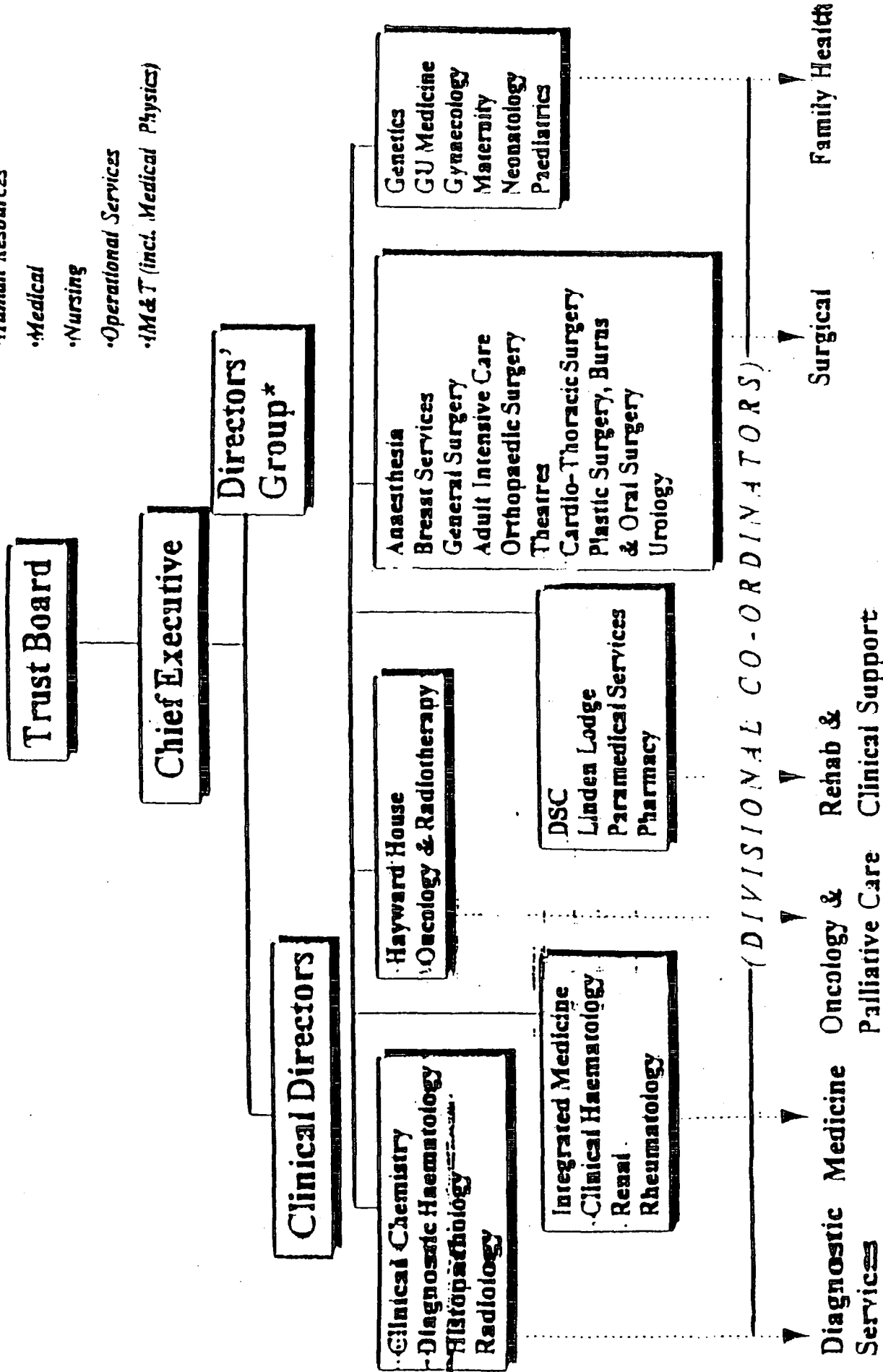
Continuing Care
 Day Hospital
 Acute Care
 District Nursing
 Domiciliary

Clinical Coding
 Clinical Nurse Specialists
 Dietetics
 Medical Photography
 Medical Records
 Outpatients
 Pharmacy

Nottingham City Hospital NHS Trust MANAGEMENT STRUCTURE

April 1996

- * *Corporate Affairs*
- *Service Development & Planning*
- *Finance*
- *Human Resources*
- *Medical*
- *Nursing*
- *Operational Services*
- *M&T (incl. Medical Physics)*



CLINICAL DIVISIONS

Family Health	Mental Health	Medicine	Surgery	Technical Specialities
- Paediatrics	- Adult Psychiatry	- General Medicine	- General Surgery	- Radiology
- Obstetrics	- Old Age Psychiatry	- Elderly Care	- Urology	- Pathology
- Gynaecology	- Learning Disabilities	- Haematology	- Orthopaedics	- Anaesthetics
- Child Psychiatry	- CPN Service	- Rheumatology	- A&E	- ITU
- Family Planning		- GU Medicine	- Oral Surgery ^(*)	- Operating Theatres
- Learning Disabilities		- Dermatology ^(*)	- Orthodontics ^(**)	- Day Surgery
- Health Visiting		- ECG	- ENT ^(*)	- Out-Patients
- School Nursing		- CCU	- Ophthalmology ^(*)	- CSSD
- Speech Therapy		- District Nursing	- Plastic Surgery ^(*)	- Pharmacy
- Community Dental Service		- Dietetics		
		- Rehabilitation		
		- Chiropody		

(*) Out-patient service from South Tees Acute Trust

(**) Day Surgery/Clinics from South Tees Acute Trust

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