TALKING POINTS

Griffiths and doctors—some reflections

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The recommendations of the Griffiths inquiry are based on four main conclusions.¹ Firstly, the roles and responsibilities of ministers and their officials, and of chairmen, members, and senior officers of National Health Service authorities, require separation and clarification. Secondly, decision taking needs to be devolved as far down the structure as possible—that is, closer to where doctors and nurses work. Thirdly, the processes of decision taking and implementation require speeding up, with responsibility for action more clearly defined. Fourthly, clinicians should be more closely concerned in the management of resources at unit and hospital department level to ensure that their use is efficient and effective. While this diagnosis has not been seriously challenged, the Griffiths treatment plan has.²⁻⁴

Unfortunately, the report is terse to the point of opacity in places. Neither this nor the breathless haste with which it has been processed through consultation to decision has allowed much in the way of informed debate. Moreover, because attention throughout the NHS has focused closely on the proposal to appoint general managers the merits of other proposals have received less consideration than they deserve. Some are worth closer examination from the standpoint of their effect on doctors as well as to set the general management issue in context.

National level

Within the Department of Health and Social Security a health services supervisory board is proposed, chaired by the Secretary of State and including the Chief Medical Officer among its members. It has now been established and is to be concerned with the determination of purpose, objectives, and direction for the NHS; approval of the overall budget and resource allocations; strategic

decisions; and receiving reports on performance and other evaluations from within the NHS. Below the supervisory board, and responsible to it, a small multiprofessional NHS management board is proposed to plan implementation of the policies approved by the supervisory board; to give leadership to the management of the NHS; to control performance; and to achieve long term consistency and drive. Its chairman will "perform the general management function at national level."¹

Underlying these two proposals is the belief of Mr Griffiths and his colleagues that "a small strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS) to ensure that responsibility is pushed as far down the line as possible."¹ Put another way, it implies that the DHSS meddles too much in detail and is overstuffed—a view that may find echoes among practising doctors and health service managers. More seriously, if these boards do bring coherence to central management and to the disparate arms and organisations within the NHS they will be most welcome. This is particularly so if, as has been suggested, the intention is to ensure that ministerial or other initiatives are carefully thought through in terms of their timing, effect, and cost before being unleashed on the NHS. The NHS landscape, however, has seen several false dawns in the past decade, and it remains to be seen how effective these boards will be in controlling ministerial caprice or Civil Service whim.

The experiences of last year illustrate perfectly the waste and chaos caused at the sharp end of the NHS by the lack of what Griffiths describes as "an orderly management process" at government and DHSS level. In January 1983 regional health authorities were told their revenue allocations for the financial year 1983-4.⁵ By early spring regional health authorities had told district health authorities how much money they could spend between April 1983 and March 1984. Armed with this knowledge districts in turn told their hospitals and community units how much cash they had for expanding, contracting, or maintaining services, depending on local circumstances. No sooner had implementation of this planned spending begun than, in July, the "Lawson cuts" were imposed throughout the NHS. Authorities and management teams at district and unit level obediently changed tack and began pruning programmes and making savings to meet the new cash limits. Then parliament went into recess, whereupon ministers and the DHSS chose August to announce manpower cuts of up to 1% to be applied to every NHS authority.⁶ Management effort at regional, district, and unit level was redirected once more to cope with this new requirement—yet again diverting attention and scarce managerial resources away from the planning and operation of services to help

doctors to care for their patients. Small wonder then that one administrator summed up the battle weary cynicism of clinicians and management teams alike by describing the handling of these events as "crude, indiscriminate, and irrational, creating a tremendous workload and bad press for little overall effect."⁷

Regional level

There are unanswered questions here of importance to doctors, but unfortunately Griffiths is at his most Delphic when dealing with regional health authorities. The role of regions is to be strengthened, concentrating on planning, resource allocation, and control. Yet, apart from a few services such as blood transfusion and the ambulance services of some large cities, regional health authorities manage virtually nothing at first hand. Moreover, the report itself emphasises that districts, hospitals, and units are to be "liberated to get on and manage the service."¹

Certainly, regions have a role in calling district health authorities to account for their performance against agreed criteria, but the degree to which any regional general manager could be held accountable for the activities of a separate autonomous district is quite unclear. Even less easy to define is the intended relation between a non-medical regional general manager and the consultants whose contracts are held by his regional health authority.

District and unit levels

It is at these levels that, if implemented, the Griffiths proposals will have the greatest and most visible impact on health care and the practice of medicine. Apart from the vexed question of general managers there are one or two other proposals of interest to doctors.

One such is for cost improvement programmes to be initiated. Translated into English this means trying to get better value for money by, for example, going out to open tender for catering, cleaning, laundry, and perhaps works services to see whether the existing NHS based service is competitive. Putting aside the bitter arguments of political principle that surround this issue, the experience of several health authorities (including my own) shows that sometimes the NHS service is cheapest and best and sometimes it is not. In either event, savings of several hundred thousand pounds have been found and ploughed back into clinical services. The profession should perhaps warn, however, that the degree to which this process can remedy the overall shortage of resources for the NHS perceived by most clinicians in their

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daily work remains to be seen. Finding resources from these efficiency programmes will not resolve the wider questions of how much the United Kingdom can afford or should afford for health care—it merely postpones the debate.

Two other linked proposals will affect doctors profoundly—"to involve the clinicians more closely in the management process consistent with clinical freedom for clinical practice," and "to ensure that each unit develops management budgets."¹ Again, informed debate on these important issues has been hampered by lack of definition of terms like management budget, clinical budget, and specialty budget, and also by the fact that studies in six hospitals commissioned by the inquiry have not been completed.

General manager

In the view of Griffiths the best way of cutting through the delay and bureaucracy perceived in the NHS is to appoint a general manager at national, regional, district, and unit level, responsible for seeing that decisions are taken and implemented. Day and Klein see a move from consensus to conflict implicit in the Griffiths report in general and in the proposal for a general manager in particular.² Dyson goes further and talks of a "long and divisive conflict between the administrative and medical professions that will result from direct or indirect attempts to curb clinical freedom."³

These views seem to be based in part on the assumption that managers and clinicians will disagree more often than not. Recurring clashes between autocrats are implied. While it would be idle to pretend that conflict does not occur, it surely does less than justice to the many consultants and general practitioners who contribute to the smooth running of the service inside or outside management teams to place undue emphasis on the conflict view of the NHS, particularly "doctors versus the rest." Moreover, if management is seen as "getting things done through people" the management process rests essentially on the twin pillars of consent and respect, neither of which is the same as consensus. A good manager anywhere deploys facts, logic, and persuasion in search of consent, and only if these fail does the question of overriding opposition arise. A look at industry shows that, while there are some equivalents of King John among the barons, there are not too many Ghengis Khans about.

The question of respect is an important one, too. It is the case—unpalatable perhaps but true—that many doctors view administrators much as an officer corps views its warrant and non-commissioned officers—good chaps whose function is not to think or plan but to take orders and keep things running. This view is, of course, grossly unfair to many able administrators and to some doctors and also conveniently ignores the existence of mediocrities in our own ranks. Nevertheless, the view exists and does have an important bearing on the selection of the general manager at any level, as well as his ability to carry out his tasks.

Despite the fact that Griffiths makes clear that the general manager may be of *any discipline* and could come from within the existing management team or *outside*, much of the debate has been conducted on the assumption

that he (or she) will in most cases be an administrator. Will this necessarily be so? And perhaps more important, should it be so? Or should some or most general managers be doctors?

The attitudes of doctors to participation in management vary from a distaste for an activity perceived as unclean through, rather less frequently, interest and helpful co-operation to, occasionally, driving enthusiasm. Yet in the nature of things our profession is arguably the largest reservoir of intellectual ability in the NHS; is trained in problem solving; and is accustomed to making decisions. What is more, a considerable number of clinicians privately admit to a degree of boredom with the clinical life and indulge their managerial talents by variously taking up politics (parish, local, medico, or national), farming, the bench, and so on. Why not, given adequate training, a second career in management? After all, Griffiths himself says "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."⁴

If Griffiths does come to pass, the first selection of general managers at district level is likely to be mainly administrators with a few community physicians, treasurers, and nurses. At unit level also administrators are likely to predominate. Then, after the expiry of the first round of fixed term contracts in three to five years, the next generation of general managers is likely to contain even fewer doctors. This faces our profession with some choices. One is to acquiesce in a pattern of organisation in the NHS whereby leadership in important areas is ceded to others, with the medical role reduced to providing advice laced with criticism. Another is to take the view that medical training and experience are uniquely important contributions to the practice of management in a health service and that clinicians should be one of the main sources of recruits for general management posts. This in turn will require a rethink about medical training at both undergraduate and postgraduate levels (as suggested by Griffiths), as well as of medico-political attitudes.

We are a conservative profession. This undoubtedly has advantages for our patients and ourselves. It may have disadvantages also—notably a sluggish reaction to change and opportunity. Let us hope Sir John Hoskyns did not have medicine and Griffiths in mind when he said that "the establishment fears change as a decaying aristocracy fears revolution."⁵

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Junior hospital doctors' posts: remaining one in two rotas

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The Department of Health's circular PM(82)37 asked district health authorities to set up working parties to examine the hours of work of their junior hospital doctors and wherever possible to reduce rota commitments to one in three or better by August 1983.¹ The progress made by districts towards this goal was surveyed by the DHSS in the autumn of 1983, and regional health authorities were asked to summarise the data from their districts before they were presented to the DHSS. The summary statistics for the South Western Regional Health Authority are reproduced here as a basis for wider discussion on the desirability and feasibility of reducing the number of one in two rotas. (The term one in two is used to include the small proportion of rotas that are worse than one in three but not quite as frequent as one in two.)

Position at 1 August 1983

Table I shows the proportion of all junior posts that still carried an on call commitment worse than one in three at 1 August 1983: about one quarter. This proportion was remarkably constant across different grades, but considerable variation was evident between different districts (range 14-45%). Two possible causes for district variability were examined, but neither yielded an explanation.

Firstly, it seemed reasonable that districts with small junior staff establishments might have experienced more difficulty in arranging cover than districts with more staff, but there was no relation between the two (figure). Secondly, rota reductions might have been more difficult to achieve in districts where more than one major hospital site accepted acute medical and surgical patients or both. The proportion of one in two rotas among districts where there was only one major hospital site, however, did not differ from the proportion in the other districts (table II).

Rota changes achieved between March and August 1983

In March 1983, when the preliminary reports of the district working parties were submitted, 25.6% of the region's posts carried

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