TALKING POINT

Role of the consultant in NHS management

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Most doctors probably know that the Secretary of State has asked Mr Roy Griffiths, deputy chairman and managing director of J Sainsbury, to advise him on the efficiency of the National Health Service management.¹ The report will be private, but it will have an impact on the NHS if its recommendations are acceptable to the Secretary of State and, presumably, after there have been consultations on the recommendations that the government proposes to implement. The National Association of Health Authorities and the Institute of Health Service Administrators have commented on the issues being considered, but, although representatives of the profession have had talks with Mr Griffiths, there has been little comment in the official medical press. I should like to stimulate more general discussion, particularly among consultants who are likely to be most affected by any managerial changes. I should emphasise that I have no inside knowledge of Mr Griffiths's thinking.

Present arrangements

Since the 1974 reorganisation of the NHS district management teams have controlled the day to day administration of all district services. The decisions have depended on a consensus between the three main components of the team—administrative, nursing, and medical. In many places this arrangement has worked surprisingly well, although it has suffered from two major weaknesses—a delay in making a decision when a consensus cannot be reached and the achievement of consensus by compromise when a more clear cut decision might have been desirable in the interest of true efficiency. Moreover, the system must suffer from the fact that, while the district administrator and the district nursing officer operate in a hierarchical system that allows them to impose the decisions reached on subordinates, the consultant and general practitioner members are representatives and must “sell” decisions to their colleagues. The same considerations are likely to apply to unit management as it develops. Not surprisingly, perhaps, such a system may not be seen as highly effective when viewed by someone accustomed to the more precise patterns of management operating in the commercial world, and it must be expected that changes will be recommended. Such changes may give to some individual in the team ultimate authority to impose a decision when, otherwise, no decision or an unsatisfactory one would be forthcoming. For convenience, such an individual might be referred to as a “chief executive.”

Chief executive concept

Theoretically, the chief executive might be any one of the three components of the existing district management team. In practice, it would rarely, if ever, be a doctor, even a district

medical officer, because to discharge such a role the individual would need to abandon all medical work and work full time in administration, and it would be exceptional to find someone with the level of administrative expertise necessary to command all the areas of activity in a district. Few doctors would be willing to accept such a change in their professional lives, and few health authorities, I suggest, would be happy to see a doctor assuming such authority. In practice, therefore, it is likely that a chief executive would be an administrator, and many doctors may be uneasy at the prospect of handing over such power to their current district administrator; allowing for the fundamental differences between the Health Service and most commercial operations, however, there may be serious problems in bringing in experienced administrators from outside.

If a single individual is to have ultimate authority when complex decisions on resources are made thought must be given to whether such a function could be effectively discharged by anyone other than a doctor. At the time of the Royal Commission on the NHS² the BMA expressed the view that if a chief executive were to be appointed he should always be medically qualified. A doctor would obviously have the advantage of clearer insight into the nature of medical decision making, but an administrator might well have a better understanding of the mechanisms of resource allocation in the district, an important asset if the chief executive is to be effective. It would be impossible to seek to control the nature of the decisions made by doctors in the care of the individual patient, and a medical or lay chief executive would have to exercise his authority in relation to the facilities to which doctors have access—not a new concept.

Perhaps many consultants would not be sorry to see the end of those prolonged and inconclusive meetings that try to determine how the latest set of cuts in beds or theatre facilities are to be shared among the units concerned. The most direct influence exercised by a chief executive on the pattern of practice followed by doctors must be in determining the size of unit budgets, and if he commanded the confidence of consultants his influence might be wholly helpful. If consultants could be assured that the money made available to them was, indeed, the maximum that could be allocated to patient care and that all extravagance had been eliminated from non-clinical expenditure attitudes to budgetary control might well become more cooperative. The chief executive committed to this objective might become a welcome figure in any Health Service district.

Problem of clinical autonomy

Absolute clinical autonomy is largely a philosophical concept that does not exist. A doctor treating a millionaire in a superbly equipped private hospital might be said to command full clinical autonomy. In all other circumstances considerations other than the doctor's judgment of the patient's need inevitably intrude. The NHS has preserved clinical autonomy more meticulously than have many other, conceptually freer, systems of health care. Even so, although a doctor in the NHS is free to decide on his patient's investigation or treatment, his clinical autonomy is diminished if the investigation or treatment is not available for months or years because of waiting lists.

Some doctors think that the work that they are doing is so

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Access to social service records

The General Medical Services Committee has advised local medical committees that the Department of Health and Social Security's guidance to local authorities on disclosure of information is not legally binding.¹ It has suggested that committees should consult their local authorities to see if they are instituting programmes for access to records and that doctors should be notified of the possible dangers of supplying information or giving advice, the confidentiality of which could no longer be assured, to local authority departments.

The guidance circular states that "in future—with a number of necessary exceptions—those clients who wish to have access to written records should be allowed to do so." Among the reasons given for withholding information is to protect sources of information. Doctors, hospitals, health visitors, and other social service agencies, for example, often give information to social services departments on the understanding that it will be kept private or at least that its sources will not be revealed

to or be identifiable by the person concerned. Another reason would be to protect a third party. A client's record may include information about a third party that, whether given in confidence or not, could if disclosed to the client harm the third party by damaging his reputation or relationships. A third reason would be to protect the client because there may be some cases where a person receiving services would be harmed by knowing facts about himself in his case records.

The DHSS has said that additional detailed advice will be given on the application to computer held records of the data protection legislation now before parliament. The report stage of the Data Protection Bill is due to take place in the House of Lords on 24 October.

Reference

¹ Department of Health and Social Security. *Personal social services records. Disclosure of information to clients.* LAC(83)14. London: DHSS, 1983.

Revised fees for coroners' work

The fees for postmortem examinations and attendance at inquests are to be increased in two stages from 3 October 1983 and 1 January 1984. The fee for an ordinary postmortem examination will go up from £29 to £31 on 3 October and to £32 on 1 January. If the pathologist subsequently has to attend an inquest the combined fee will be £50 from 3 October and £51 from 1 January. For attending to give professional advice, other than in connection with a postmortem examination, the new fee will be £25. This will not increase again in January.

This agreement does not relate to coroners' fees payable under section 25 of the Coroner Act 1887, for which agreement has already been reached with local authorities and back-dated to 1 April 1983 (10 September, p 766).

The new fees have been negotiated by the BMA's private practice committee. They are available to members, who should quote their current membership number and the reference "Fees 7." A stamped addressed envelope would be appreciated.

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important that financial considerations should not be allowed to intrude. This is understandable, but at a time when medical technology is outrunning the capacity of society to meet the cost it is an unrealistic position to adopt. If more resources are consumed by one doctor less are available to another; and distribution of resources by accepting the demands of the most forceful protagonist or the one most willing to use ruthlessly the power of public pressure through the media is not an acceptable way to proceed. It would be quite unacceptable for doctors to be dictated to in the way that they treat individual patients, but if changes in the management structure are made to bring the maximum resources into the clinical services doctors will have to ensure that the most economical use is made of them. This kind of corporate responsibility for the use of resources must develop in this country, and the profession will have to become less delicate than it has been in criticising wasteful practices among colleagues.

Alternative proposals

The National Association of Health Authorities has suggested that the problem of financial control of clinical activities could be accomplished by making consultants answerable to the district health authority for budgets allocated to them.³ This, the association believes, could be done without encroaching on the principle of clinical autonomy. The proposition contains two fundamental difficulties. Firstly, the proportion of the budget that a consultant could directly influence—drugs, dressings, disposables, etc—represents a tiny proportion of the total expenditure that he generates. Most of this expenditure is made up of the cost of medical and nursing staff and the fixed costs of beds, wards, theatres, and the other back up services. Any savings that resulted from economies in the first group of expenditure, while useful, would be small, but unless it is proposed to give consultants the authority to close beds, sack nurses, and control the back up services, the consultant would be held responsible for matters over which he had no effective control. Secondly, the consultant could have no assurance that

the budget allocated to him represented a fair share of the total district resources. The essence of the chief executive concept is that the new officer would effectively control other expenditure to ensure that the last possible penny reached the clinical services. The perpetuation of the present structure, with additional financial answerability imposed on the consultant, would not be an acceptable alternative.

The National Association of Health Authorities believes that any change in the managerial structure must be accompanied by a transfer of consultants' contracts from regional level back to district level. This is, of course, totally irrelevant. More than half of all consultants serve more than one district, and, despite the commitment that most consultants have for the NHS, their primary loyalty must be to the patients they serve. Any other arrangement would seriously imperil public confidence in the NHS.

Conclusion

The profession could gain much from the introduction of chief executives into the Health Service. It would be essential, however, that they commanded the confidence of the medical staff and were fully committed to concentrating the maximum available resources on patient care. It is difficult to judge how many existing district administrators have such a commitment to a degree that would override old loyalties and allow a sufficiently ruthless approach to non-essential expenditure. The system is less important than the men (or women) operating it, but where would these people come from?

References

- ¹ Anonymous. Business team to inquire into Health Service. *Br Med J* 1983; **286**:578.
- ² Royal Commission on the National Health Service. *Report.* Cmnd 7615. London: HMSO, 1979.
- ³ Scrutator. The week. *Br Med J* 1983;**287**:847.

(Accepted 20 September 1983)