Doctors and management—why bother?

Jenny Simpson

This is the first in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson

Case study

In November the chief executive of St Christopher's, Mr Vincent, announced that the oncology ward would be closed for five months from the following week, for redecoration. Medical staff were outraged: this ward provided specialist oncology care for children from all over the region, and their parents gained a good deal of support from each other and from the medical staff. The oncology service had been built up over many years and provided specialist training courses for nursing and other staff. Patients were to be dispersed around the general wards and thus put at considerable risk of infection. Staff were also sure that the specialist nurses would find work in other oncology units so the hospital would lose its oncology nursing expertise.

The consultants' anger was further fuelled by the fact that, on the face of things, doctors were being encouraged to take part in management, an involvement vociferously endorsed by the general manager. The hospital had a clinical directorate structure, but very little in the way of significant decisions seemed to be discussed at the clinical directors' meetings. The atmosphere had become increasingly sour over the previous two years, and several highly respected clinicians had left for posts in the pharmaceutical industry and abroad.

The following week several consultants challenged Mr Vincent about his decision. He explained that he had taken advice from some senior key clinicians, but he

refused to name them. This resulted in much speculation, suspicion, and ill feeling among the consultants. The nurses were also furious and felt that they had been betrayed by trusted colleagues. The atmosphere was extremely tense, and at the end of the week Dr Roberts called a meeting of the medical staff.

At the meeting it transpired that no one had, in fact, advised Mr Vincent about the subject of the oncology ward. All the consultants agreed that the situation was unacceptable, but they were at a loss as to how to resolve it. They took advice from a wide range of sources, including the trust's chairman, who came to the conclusion that the relationship between Mr Vincent and the clinical directors would not support the successful operation of the trust. Mr Vincent was redeployed and Dr Parker, a pathologist with many years' experience in chairing medical staff and a number of district and regional committees, took over as chief executive.

The management process in the hospital rapidly improved, as did the consultants' morale. But things were not so comfortable for Dr Roberts. Shortly after Mr Vincent took up his new post, Dr Roberts was summoned to the chairman's office. The chairman had been very supportive of Dr Roberts's involvement, but now told him that he had been a disruptive influence in the hospital, that he was "far too articulate" in meetings, and that he should leave the hospital that afternoon.

Learning points from the case

THE KEY RELATIONSHIP BETWEEN CHIEF EXECUTIVE AND CLINICAL PROFESSIONALS

No matter how sophisticated the clinical professionals' technical skills or how loyal and committed the hospital staff, unless both management and clinical professionals share a single set of values and ideals about the ultimate goals and proper functioning of the organisation, it will never flourish. The mismatch in attitude at St Christopher's between clinical staff and the chief executive had resulted in a distrustful atmosphere, which eventually permeated the entire organisation, making it an unpleasant place in which to work. In these circumstances, talented staff leave and it is difficult to attract high calibre new applicants to replace them. Managerial skill on the part of the chief executive, managerial commitment on the part of the clinical professionals, and determination to develop a trusting respectful relationship by both managers and clinicians are essential preconditions for the long term strategic health of a hospital.

DECISION MAKING SHOULD BE EXPLICIT AND INFORMATION BASED

Effective decision making in today's health care organisations is made on the basis of explicit information. Clinicians form a valuable source of information and expertise, which Mr Vincent failed to use in his decision making. They expect to be part of the explicit and information based processes. Considerable unrest ensues if this does not happen. As technology advances, the arguments of five or 10 years ago, that the information simply is not available, are no longer tenable.

DECENTRALISATION ON PAPER MUST BE BORNE OUT IN PRACTICE AND BY MANAGEMENT PROCESSES

Decentralisation of management responsibility to clinical resource centres entails a true devolution of management authority. Decentralised organisation structures can function only if those leading clinical services are sufficiently empowered and supported by central management to make significant and far reaching changes in the organisation of their own services, and to make a contribution to the management of the hospital as a whole.

Failure to devolve management authority leads to scepticism among clinical staff, who feel that they have taken on the blame for any overspending, but are powerless to do anything about it. This rapidly leads to disenchantment and distrust, and, as took place at St Christopher's, a deterioration in what may already be vulnerable relationships.

THE POWER OF WORKING AS A TEAM

Doctors are not, by culture or tradition, strong corporate team players. The nature of their profession, with ultimate named responsibility for individual patients, dictates an organisation of single players, albeit supported by their own teams of juniors. This means that many doctors gain little experience of working as equal players in teams. The exceptions are those who work across specialties—for example, in intensive care or in rehabilitation units. To work effectively in a team requires a different set of skills from those required as a single player, and not all doctors manage to acquire these skills. Sometimes, however, as at St Christopher's, the clinical staff are galvanised by adversity into adopting strong corporate

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behaviour, and once team behaviour is established it can be developed further.

A group of clinicians working effectively together on management issues is far more powerful than a single voice and can often bring about major change. But such effective corporate behaviour can be perceived as extremely threatening to the management and can result in reactive behaviour, which can be seriously disruptive. In the case study, Dr Roberts was seen by management as being responsible for loss of managerial control, and most particularly for Mr Vincent's downfall, and was duly removed.

All leadership is show business. All management is show business. That doesn't mean tap dancing; it means shaping values, symbolising attention—and it is the opposite of administration.

Tom Peters²

The doctor in management—setting the scene

Hospitals have a complex organisational structure in which professional providers of the service and managers of the infrastructure cohabit, with varying degrees of harmony. Hospitals are far from straightforward to manage.

As in other service industries, the quality of the "product" of health care is determined by the expert skills and knowledge of the front line workers—the clinicians—who, by every decision they make, commit whatever resources are available. The non-clinical managers cannot directly control their activity. Thus the mechanisms for managing in a manufacturing context—where hierarchical control and decision making by those with a superior knowledge base (at the top of the organisation) is exercised over the less skilled and knowledgeable front line workers—do not apply. Tensions between professionals and managers are inevitable and can either catalyse the formation of strong and effective teams of doctors, nurses, other professionals, and managers or, as at St Christopher's, can be mishandled and destroy any possibility of working together.

Today's clinicians and managers work in an environment that has evolved since 1983, when Sir Roy Griffiths responded to the NHS Management Inquiry. "The nearer that the management process gets to the patient, the more important it becomes for doctors to be looked upon as the natural managers."¹ The decision facing the manager centres on the extent to which he or she is prepared to devolve the centralised power base of long term decision making, budgets, resource allocation, and information to those more directly involved in patient care. With devolution, however, the manager is not absolved of the final responsibility for the proper functioning of the organisation. The reason that health care provision demands an extremely high calibre of manager is that it is, indeed, difficult to devolve power, authority, and budget responsibility while at the same time retaining a leadership position.

Involvement in management for the clinician can be a time consuming, emotionally draining, and at times nerve racking experience. Time devoted to management activities, let alone education, is inevitably in conflict with either clinical or private time, and in an unsupportive organisation may have no financial reward. Yet doctors are increasingly taking on the roles of clinical director, medical director, or other clinical and management combinations. Furthermore, these doctors, while initially perhaps being motivated by a sense of duty, are now keen to improve their management skills and enthusiastic to continue in their new roles. Indeed, some who have completed a fixed

term—for example, as a clinical director—have found the experience so rewarding that they wish to continue, and in some cases make a permanent career move. Many doctors find that dealing with the wider picture, gaining the opportunity to influence the organisation as a whole and the direction it will take, provides a refreshing and stimulating challenge, particularly when set against the perspective of their clinical duties. They find that solving management problems appeals to their creative talents and is both exciting and challenging.

Doctors must decide for themselves how much time and energy they will invest in a managerial role and the learning process required to make a meaningful contribution. The role of any senior clinical practitioner has managerial components—achieving goals through motivating others, monitoring and developing the performance of juniors, making complex long term decisions, and organising workload. There is a strong argument for education on management for all doctors at both undergraduate and postgraduate levels. However, the decision to take on an active role in hospital management should not be undertaken lightly, nor without a clear understanding not only of the demands and nature of the task but also of the considerable rewards. Doctors must also think carefully of the consequences of not being involved in management, at an individual as well as a professional level.

How have doctors and managers traditionally regarded each other?

In the past doctors may have perceived in managers a value system driven by a need to keep the district or regional headquarters happy, making decisions that were politically and financially acceptable rather than being driven by patients' needs or the quality of their care. Decisions were often perceived as being taken behind closed doors by some mysterious process and then delivered to the medical staff, with or without the veneer of a consultative process. Furthermore, it was commonly perceived that a "management mafia" existed, designed to keep the manager committed to "not rocking the boat," in position to increase the control of district (as it was then) and regional headquarters. Such views were widely held at St Christopher's.

The leader—cheerleader, enthusiast, nurturer of champions, hero finder, wanderer, dramatist, coach, facilitator, builder.

Leadership by means of passion, care, intensity, consistency, attention, drama, using implicit and explicit symbols.

Tom Peters⁴

For the manager's part, doctors in many instances have been regarded as an unruly bunch of mavericks with more power than is desirable and no sense of responsibility for the hospital as a whole. Medical staff have been perceived as extremely poor team players, interested only in their own clinical empires with very little appreciation of the world outside medicine and the environment in which the organisation exists. In many instances managers have taken something of a patronising stance, ridiculing doctors' lack of awareness and management acumen.

The lack of a common dialogue between doctors and managers has led to considerable frustration in many clinicians. At St Christopher's the consultants felt that their intimate and expert knowledge of the systems and processes, the business of the hospital, was wasted as they were unable to effect any significant change within the organisation. This sort of situation is not helped by

the tradition of senior doctors tending to stay in the same institution for many years, often for their entire career, gaining little experience of other management cultures and limiting their understanding of the possibilities for change.

Ten years on from the Griffiths inquiry, and influenced in great measure by the more recent initiatives of *Resource Management* and *Working for Patients*, there has been a dramatic change in attitude on the parts of both doctors and managers. In many parts of Britain the old relationships are barely recognisable. However, the changes are by no means uniform; there are still some hospitals in which suspicion and distrust predominate.

Medical managers—leaders or administrators?

Management is concerned with getting things done through influencing others. It is concerned with making decisions, not only on a day to day basis, but also the long term, strategic decisions which determine the direction that the service or organisation will take.

***“... an unruly bunch of mavericks
... interested only in their own
clinical empires ...”***

The doctor in management must learn to be a team player, and also take on a leadership role among his or her colleagues. Charles Handy defines the leader as someone who “shapes and shares a vision which gives point to the work of others.” The leader must describe and develop a vision of precisely why the organisation exists, to what end, for whose benefit. In the light of this definition the leader must examine every single structure, process, and approach to making decisions and all the activities that make up the hospital organisation, and if necessary redesign them to ensure that they are geared towards supporting this ideal. At St Christopher’s, Dr Roberts took on this role in the course of the organisational changes largely because Mr Vincent did not; there was a leadership vacuum which eventually required resolution.

The traditional perspectives and skills of doctors—observation, analysis, diagnosis, problem solving, and developing action plans—when applied to the broader picture of the organisation as a whole rather than to a specific patient, serve as an effective framework on which to base management and understanding of leadership. There is no mystique to management: its subject matter, approaches, and language may be readily learnt by interested doctors and translated into the health care environment. To be an effective leader requires an intimate understanding of the structures in the organisation: its anatomy (an understanding of the system); its physiology (the systems and processes); and the environment in which the organisation exists.

Understanding the anatomy

The structure of an organisation plays a major part in determining how it works and with what effect. The structure defines who reports to whom and the levels at which decisions are made. Hospitals are complex entities in managerial terms, considerably more complex than one would be led to believe by either the status of management in health care in the United Kingdom or the emphasis placed on investment in educating or training managers of appropriate calibre.

Hospitals are not simple, hierarchical structures but, along with universities and other educational establishments, fall into the category of “professional bureaucracy” as defined by Mintzberg.⁵ This type of

structure is characterised by a central operating core of the most highly skilled and intensively trained individuals (the clinical staff providing the service for patients). The management role in this type of bureaucracy is to underpin the professional activity and to ensure that the “product,” in this case the clinical process, is supported by groups of appropriate and effectively functioning staff. The non-professional manager cannot control the activities of the professional operating core and must therefore adopt a very different management style from that of an executive in a production orientated hierarchical environment.

The involvement of clinicians in the management process formalises and makes explicit the need for the professional body to make responsible and informed management decisions which will have a significant impact on the functioning of the organisation as a whole. Although the concept of decentralising the controlling role of management and the terms “supportive” and “coordinating” might initially be perceived as requiring a weaker, less skilled manager, this is far from the case. The professional bureaucracy demands a skilled, sensitive manager who is capable of leading from the side, drawing on the skills and leadership qualities of the medical and nursing staff and pulling the decentralised clinical teams together to form an effective, corporate whole. Had Mr Vincent been prepared to take a less autocratic stance, and behaved more as a coordinator, the situation at St Christopher’s may well have been averted if a single decision making body had been established. This would have allowed all the clinical directors and the management executive to make a joint decision concerning the running of the hospital, as advocated in *Managing Clinical Services*.⁵

Understanding the physiology

Running hospitals involves complex processes. Set against the wider political organisation of the NHS as a whole, the organisational issues become ever more complicated, posing a considerable challenge to anyone attempting to disentangle the basic processes of decision making, financial allocation, and policy making. However, an understanding of these systems and processes, of how things happen in the NHS, is essential to the clinician who wishes to make a truly effective contribution to management, and greatly increases his or her chances of influencing either the input, the process, or the output. Most importantly, the clinician needs to understand the systems by which information flows through the organisation; decisions are made; and decision making is communicated and implemented throughout the organisation.

Peter Drucker, a leading authority on management processes for the past 50 years, has identified five areas of expertise required for effective management.⁶

In the world of trusts and clinical directorates many of the convoluted processes and multiple levels at which decisions were made within individual systems have been replaced by a more direct form of both operational and strategic decision making. This should result in more straightforward processes, with those

Drucker’s five talents for effectiveness in management

- 1 Time management
- 2 Identifying the particular contribution to the organisation
- 3 Identifying where and how to apply particular strengths to best effort
- 4 Setting the right priorities
- 5 Effective decision making

who are expected to implement decisions much more closely involved in the way they are made. However, not all provider units are undergoing instant and complete change. Many—as at St Christopher's, where clinical directors were in place but not making any effective contribution to the management process, exhibit both old style and new style management arrangements simultaneously, somewhat to the confusion of the clinical staff. A more detailed appreciation by the consultant staff of the process at work at St Christopher's would perhaps have resulted in a less traumatic series of events.

The environment

Not only are the structures and processes of health care management complex, but the environment, both internal and external, of health care provider units is also far from stable. It is an inescapable fact that health care in the United Kingdom, as in many other countries, is inextricably linked with political issues, and the effects of this are felt at all levels of the service. Technological advance has a widespread influence on both clinical activity and consumption of resources, and published effectiveness and outcomes information may significantly alter the course of clinical practice. At a more local level, a wide range of external environmental factors affects the way in which the organisation functions—for example, its location or the personality and disposition of key purchasers.

"To be an effective leader requires an intimate understanding of the structures of the organisation."

In terms of internal environments, there may well be power struggles—between groups of clinicians or between clinicians and management—which can undermine the organisation's operations. An understanding of all the dimensions of the internal dynamics and the specific knowledge and skills to build a cohesive team among the key players can dramatically improve the internal environment. At St Christopher's the key environmental factors were external politics and upward relationships. A greater insight into and influence on these dynamics might have averted the situation and protected Dr Roberts's position.

So why bother with management?

Doctors currently have the opportunity to have a full and active role in management, and it is vital for the

Key messages

- Doctors must be involved in management decisions to influence the strategy of their organisation and, therefore, the welfare of their patients
- A single decision making body should be in place in every health care organisation, comprising significant numbers of doctors and managers, at which every major decision concerning the organisation is made
- Doctors' skills acquired in clinical practice can be used as a framework for management practice
- 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
- Explicit information based systems and team work are vital components of a decentralised management structure

future health of our hospitals and other health care organisations that this culture is maintained by clinicians taking up the challenge. Because hospitals and other provider units are complex to manage, the highest calibre and best informed management is required. Clinical professionals in all disciplines must play their part in demanding high calibre management—but must also be prepared themselves to make a significant and high quality contribution to management processes. The role of the doctor in management is to ensure that we "do things right, and do the right things." Doctors should play an active part in management not because it is the current fashion, or because "it is their turn" but because, for the benefit of patients, it is essential that the finite resources of the NHS must be invested on the basis of informed decision making. Without active involvement from clinicians in the management process poor decisions will continue to be taken, damaging organisations and patient care, just as they did at St Christopher's.

- 1 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 2 Peters T, Austin N. *A passion for excellence*. London: Collins, 1986:263.
- 3 Handy C. *The age of unreason*. Arrow, 1985:106.
- 4 Mintzberg H. The professional context in the strategy process. In: *Concepts, Contexts and cases*, eds. Quinn, Mintzberg, James, 638-49, Prentice-Hall, 1988:638-49.
- 5 British Association of Medical Managers, British Medical Association, Institute of Health Services Management, Royal College of Nursing. *Managing Clinical Services*. London: IHSM, 1993.
- 6 Drucker P. *The effective executive*. London: Heinemann, 1986:138-44.

A PATIENT WHO CHANGED MY PRACTICE

Like mother, like daughter

As always I saw the child first, alone. Mary was a bright, friendly, articulate, and caring 9 year old. She was puzzled and distressed by her inability to please her mother. Mother was an attractive, concerned parent of 30. She could say nothing good and much bad about her daughter. She expressed her criticism in extravagant language. As I often do I jotted down verbatim quotes. She said that she had been brought to the same clinic by her mother when she was 9.

Obtaining her maiden name I had her file on the desk within minutes. By incredible good fortune the psychiatrist who had seen her 21 years before had also taken verbatim quotes. I was astonished to see that her mother had criticised her in exactly the same words that she was now using to describe her daughter. We read through the

notes together. Her whole demeanour and attitude changed. Mary joined us and we shared our discovery. It was an emotional experience. Mary and mother left arm in arm and appreciating each other for the first time ever. When I saw them again a month later the new and rewarding relationship had burgeoned. I rang the mother a year later and she described her daughter proudly in glowing terms. Furthermore, she volunteered that she was getting along much better with her own mother.

Since that time one of the most meaningful questions I can ask a parent is "How was it for you when you were Mary or John's age?" Very often it was very like how it is for Mary or John today and often provides the key to unlock today's unhappy situation.—HARVEY J MARRABLE is a psychiatrist in New South Wales