- 10 Niaudet D, Broyer M, Habib R. Treatment of idiopathic nephrotic syndrome with cyclosporin A in children. *Clin Nephrol* 1991;35:831-6.
- 11 Nolasco F, Cameron JS, Heywood EF, Hicks J, Ogg C, Williams DG. Adult-onset minimal change nephrotic syndrome: a long term follow-up. *Kidney Int* 1986;29:1215-23.
- 12 Melocoton TL, Vanni ES, Cohen AS, Fine RN. Long-term cyclosporin A treatment of steroid-resistant nephrotic and steroid-dependent nephrotic syndrome. *Am J Kidney Dis* 1991;18:583.
- 13 Pei Y, Cattaran D, Delmore T, Katz A, Lang A, Rance P. Evidence suggesting undertreatment in adults with idiopathic focal segmental glomerulosclerosis. Regional glomerulonephritis registry study. *Am J Med* 1987;82:938-44.
- 14 Siegal NJ, Gaudio KM, Krassner LS, McDonald BM, Anderson FP, Kashgarian M. Steroid-dependent nephrotic syndrome in children: histopathology and relapses after cyclophosphamide treatment. *Kidney Int* 1981;19:454-9.
- 15 Schena FP, Montenegro M, and Scivattaro, V. Meta-analysis of randomised controlled trials in patients with primary IgA nephropathy (Berger's disease). *Nephrol Dial Transplant* 1990;suppl 1:47-52.
- 16 Mustonen J, Pasternack A, Rantala A. The nephrotic syndrome in IgA glomerulonephritis: response to corticosteroid therapy. *Clin Nephrol* 1983;20:172-6.
- 17 Donadio JV Jr, Torres VE, Velosa JA, Wagoner RD, Holley KE, Okamura M, et al. Idiopathic membranous nephropathy: the natural history of untreated patients. *Kidney Int* 1988;33:708-15.
- 18 Schieppati A, Mosconi L, Perna A, Mecca G, Bertani T, Garattini S, et al. Prognosis of untreated patients with idiopathic membranous nephropathy. *N Engl J Med* 1993;329:85-9.
- 19 Ponticelli C, Zucchelli P, Imbasciati E, Cagnoli L, Cesana B, Pozzi C, et al. A controlled trial of methylprednisolone and chlorambucil in idiopathic membranous nephropathy. *N Engl J Med* 1984;310:946-50.
- 20 Ponticelli C, Zucchelli P, Imbasciati E, Cagnoli L, Pozzi C, Passerini P, et al. A randomized trial of methylprednisolone and chlorambucil in idiopathic membranous nephropathy. *N Engl J Med* 1989;320:8.
- 21 D'Amico G. Influence of clinical and histological features on actuarial renal survival in adult patients with idiopathic IgA nephropathy, membranous nephropathy and membranoproliferative glomerulonephritis: survey of the recent literature. *Am J Kidney Dis* 1992;20:315-23.
- 22 Tarshish P, Berstein J, Tobin J, Edelman C. Treatment of mesangiocapillary glomerulonephritis with alternate-day prednisolone: a report of the international study of kidney disease in children. *Pediatr Nephrol* 1992;6:123.
- 23 Donadio JV Jr, Offord KP. Reassessment of treatment results in membranoproliferative glomerulonephritis, with emphasis on life-table analysis. *Am J Kidney Dis* 1989;14:445.
- 24 Schena FP, Cameron JS. Treatment of proteinuric glomerulonephritides in adults. *Am J Med* 1988;85:315.
- 25 Tejani A, Ingulli E. Poststreptococcal glomerulonephritis. Current clinical and pathologic concepts. *Nephron* 1990;55:1.
- 26 Rees AJ, Cameron JS. Crescentic glomerulonephritis. In: Cameron JS, Davison AM, Grünfeld J-P, Kerr DNS, Ritz E, eds. *Oxford textbook of clinical nephrology*. Vol 1. Oxford: Oxford University Press, 1992:318-38.
- 27 Turner AN, Rees AJ. Antiglomerular basement membrane disease. In: Cameron JS, Davison AM, Grünfeld J-P, Kerr DNS, Ritz E, eds. *Oxford textbook of clinical nephrology*. Vol 1. Oxford: Oxford University Press, 1992:438-56.
- 28 Gaskin G, Pusey CD. Systemic vasculitis. In: Cameron JS, Davison AM, Grünfeld J-P, Kerr DNS, Ritz E, eds. *Oxford textbook of clinical nephrology*. Vol 1. Oxford: Oxford University Press, 1992:612-36.
- 29 Glasscock RJ, Cohen AH, Adler SG, Ward HJ. Secondary glomerular disease: systemic lupus erythematosus. In: Brenner BM, Rector FC, eds. *The kidney*. 4th ed. Philadelphia: WB Saunders, 1991:1280-98.
- 30 Austin HA III, Klippel JH, Balow JB, le Riche NG, Steinberg AD, Plotz PH, et al. Therapy of lupus nephritis: controlled trial of prednisolone and cytotoxic drugs. *N Engl J Med* 1986;314:614-24.

Management for Doctors

Getting started as a medical manager

J F Riordan, Jenny Simpson

This is the second 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

Three years after his appointment as a consultant physician, Dr B was persuaded by his colleagues to become chairman of the cogwheel division of medicine, all the other physicians having taken their turn. He coped easily with running the monthly divisional meeting, found some satisfaction in juggling the junior medical rotas, and saw his most challenging role as resisting the attempts of the surgeons to "protect" their beds.

After a year in post a keen new general manager was appointed to take the hospital into trust status; he selected Dr B with several other consultants, not all of whom were divisional chairs, to form a management board. Dr B became the first clinical director of medicine. Initially he found this difficult as his colleagues continued to run the old divisional structure in parallel with the new arrangements. Also the senior nurses in medicine were suspicious of medical involvement in their management.

After some months of regular meetings with the nurse manager, along with several training and team building sessions, Dr B found that by working as part of a team he could influence the functioning of the medical service and achieved a number of successes. These included improving the process of case note retrieval; rearranging the appointments procedure; and developing a number of enthusiastic teams to take on specific projects within the directorate. After a few months the atmosphere and communication within the directorate had improved considerably, with staff of all grades beginning to contribute their ideas and support for the new systems. On the strength of this, Dr B managed to persuade his consultant colleagues to disband the cogwheel division and set up a

full directorate structure with a number of subdirectorates. To his surprise he found that he enjoyed working with some of the newly recruited, bright, and keen business managers and took the opportunity to learn and develop new skills in negotiation, information management, time management, and financial monitoring and planning.

Now, with Dr B's three year fixed term of directorship coming to an end and the hospital well established as a trust, he has to give up his post—just when he feels he is beginning to make the most valuable contribution. Having invested time and effort into organising the directorate and understanding its functioning, Dr B is determined that it should succeed. Fortunately, a capable deputy to Dr B had been appointed and trained over the past year, and Dr B has the satisfaction of knowing that she will continue the good work.

However, Dr B's interest in management has been stimulated and he is at present discussing with the chief executive his wish to take on further management responsibility. He will probably take a lead role in coordinating management development within the trust, which has declared as one of its objectives the decentralisation of clinical management down to subunit level. The chief executive has also asked him to become the trust's medical director. Other possibilities include involvement with a region wide training scheme for medical management, helping the medical school to develop an undergraduate course on management, and making a contribution to medical management at national level within the British Association of Medical Managers.

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We live in times of constant change. There are increasing pressures for the NHS to be more efficient, more effective, and more responsive, and these are now accepted throughout the NHS.

The old approach of administering a relatively fixed and unchanged system has given way to the introduction of the techniques of general management which allow organisations to respond appropriately to

change. The introduction of general management began with the Griffiths report of 1983 and has been continued since with the introduction of resource management, followed by the white paper *Working for Patients*, with its separation of the purchaser and provider functions. Inherent in all these changes has been the idea that doctors should have a pivotal role in managing health service resources.

Under the old system hospitals were organised into a series of separate hierarchies, functioning in semi-independent fashion. The system was resistant to change. The position of divisional chairman was often filled, on the "Buggin's turn" principle, by doctors who regarded the post as a tedious but necessary chore.

With the introduction and subsequent dissemination of the resource management initiative in 1986-92 there was a major move towards integrating the various professional hierarchies into devolved directorate teams, giving individual clinical services the ability to respond flexibly to change in a coherent manner. These new structures have required doctors to take part in influencing the way in which care is delivered and in setting the future direction of the hospital. Many of those who have taken up the challenge have found it a rewarding experience, although there can be tensions between clinical practice and management.

Doctors who are not involved increasingly risk being managed by others and having less influence than at present, while those who accept directorate roles with the older divisional model in mind are likely to find themselves frustrated and disillusioned. All doctors need to understand the role of management and should contribute to it.

Making a start

Having decided to take management seriously, the aspirant doctor-manager should, as a first step, take an honest and critical look at his or her strengths and identify the weak spots. The knowledge of the totality of management, "what there is to know," and one's personal ability to get things done need cool appraisal.

"There is no substitute for learning by doing, and active experience should be sought from the beginning."

In the course of clinical training and practice many doctors will have acquired much knowledge and experience which is directly applicable to medical management. Normal clinical practice and medical audit bring familiarity with measuring activity, clinical coding, case mix, and aspects of quality. Organising junior doctors' rotas and training confer some knowledge of personnel issues.

On the other hand, many hospital doctors find themselves ignorant of the financial and accounting aspects of medical practice. Areas such as marketing, planning, and strategy may also feel alien, as do some of the broader issues of quality assurance and personnel management.

As well as assessing their knowledge of management issues, doctors should assess their management style and skills. Many very expert clinicians are rather less expert in communication and negotiation, and few have understanding of, or training in, leadership skills or working in teams.

Help with this initial assessment can be obtained either locally in the hospital or sought further afield (box). The assessment may vary from informal, personal advice at hospital level to a much more formal and structured session at a management assessment centre. Further advice will then be required to set up a training programme. If one is starting from little or no management knowledge, by far the most effective approach is to enrol on an introductory management course. This may be tailored specifically to doctors and run by the NHS in conjunction with organisations such as business schools. Such an initial course provides a good introduction to the subject and identifies areas where further training may be required. Following

this, specific training needs should be addressed. Many suitable courses, seminars, and conferences are run by individual trusts, business schools, health services management units, and other national management organisations. These are advertised in the health management press and in newsletters and other publications from the national associations (the Institute of Health Services Management, National Association of Health Authorities and Trusts, British Association of Medical Managers) and increasingly in the medical press.

"If handled positively . . . conflicts can be turned into a constructive debate."

While most doctors still equate management with the financial aspects (and a basic knowledge of these is undoubtedly important), they will benefit more from undertaking some training in interpersonal and influencing skills. Such training is necessary to understand the modern view of management as an enabling and team based process, as opposed to the hierarchical, control based view still unfortunately fostered by the more traditional medical schools. In future these skills should be taught as an essential part of the undergraduate curriculum, as is just beginning to happen in the more enlightened schools.

Nevertheless, as in many areas of medicine, there is no substitute for learning by doing, and active experience should be sought from the beginning. All doctors can and should take some part in management in the course of their clinical training. Junior doctors can start through medical or preferably multidisciplinary audit. Action resulting from the audit process translates into management at the departmental or unit level for all grades of medical staff. The doctor should take an interest in the management of his or her clinical directorate by attending meetings of the directorate and by being prepared to take part in the various management tasks involved in running the directorate—asking to see information, contributing ideas and comments.

The senior registrar looking for a consultant post should include the management arrangements in any assessment of hospital posts and should think twice before applying to hospitals where medical staff talk of "administrators" and where there is a "them and us" culture. Instead, doctors should look for hospitals

Where to get help

Unit level:

- Organisational development manager
- Training manager
- Human resources manager
- Medical director
- Chief executive

Regional level:

- Resource coordinator for doctors in management
- Regional management coordinator
- Coordinator for medical audit
- Regional postgraduate dean
- Provider development department

National level:

- British Association of Medical Managers
- British Medical Association
- Institute of Health Services Management
- National Association of Health Authorities and Trusts

Sources of funding:

- Study leave budget
- Local or regional training budget
- Sponsorship by pharmaceutical firms, etc

where clinicians are active in management and where there is a commitment to devolving management down to clinical subunits. Doctors in these organisations stand a much better chance of enjoying both a clinically rewarding career and a key role in influencing the direction in which the hospital develops.

How to get involved: the business plan

One of the best ways of playing an active part in management is to take part in drawing up the business plan. This process encompasses all aspects of the directorate and provides a valuable insight into the workings of the organisation. It may sound boring, but the business plan is now a mandatory part of the management of hospitals and directorates and can be applied throughout an organisation down to the smallest unit, ward, or laboratory. Even if business planning is not part of your organisation's culture, it is a worthwhile exercise at departmental level, among immediate colleagues.

The business plan

In essence the business plan (box) sets out to answer three questions:

- Where are we now?
- Where do we want to go?
- How do we get there?

An assessment of the current state of the unit or department is carried out in terms of workloads, staffing, use of capital and non-pay items, methods of information gathering, and financial position in terms of income and expenditure. Then a range of clear and achievable objectives is agreed. The plan then defines how these are to be achieved and how progress is to be monitored, with fallback plans for implementation if objectives are not being met.

While financial input is essential for the finalisation of the plan, much ground work can be done before the finance department is involved. Accountants appreciate dealing with a directorate that knows its business and has a clear idea of where it wants to go. Having produced a business plan for the specialty or department, it is important to feed it into the planning process for the organisation as a whole and to be prepared to modify the plan if it conflicts with the overall business plan.

What is the downside of a managerial role?

An involvement in management demands that the doctor accepts responsibility for matters which could previously be left to others. Sometimes difficult decisions have to be made, which make the doctor-manager less than popular with his or her colleagues. This may have consequences rather more far reaching than temporary ill feeling and resentment, jeopardising relationships that hitherto may have been good. Some doctors report that they are now less than likely to be awarded higher merit awards, having unwittingly crossed swords with those with power and influence on the awarding bodies.

There are undoubtedly extra claims on the doctor's time, and further difficult decisions may have to be made between clinical and management demands. This can to some extent be less of a problem if the doctor can delegate responsibility. In taking on any management post it is important to make sure that there is someone of the appropriate skills and experience to whom work may be delegated. If this is not the case it should be an essential condition to taking on the job. Many doctors find management work overwhelming, and all doctors should ensure that they are soundly

Key point summary

- Much of the current training for medical students still prepares them for hierarchical, control based structures, and does not equip them for a team based process
- Many doctors lack communication and negotiation skills. They also have a poor understanding of, and little training in, leadership skills and team work
- Introductory management skills courses, training in time management, followed up by specific training courses run by one of the national management organisations, can make good these deficits
- Hands-on experience is needed: one of the best ways of getting started is to get involved in the directorate's business plan
- Despite the inevitable tensions between clinical practice and management, the extra time commitment, the need to make unpopular decisions and the resultant feelings of isolation, management can be fun, stimulating, and rewarding

trained in the techniques of time management and delegation before taking on full management responsibility.

Conflict with colleagues is also a potential problem, although if handled positively such conflicts can sometimes be turned around into a constructive debate, which in the long run works to the benefit of all concerned. Again, management techniques to help with such situations, can easily be acquired by the interested and committed doctor.

Far more difficult to overcome, however, is the risk of professional isolation, particularly if the medical management culture in the hospital is not strong. Clinical colleagues may regard the doctor-manager as colluding with the enemy. On the other hand, non-medical managers, who see doctors as a threat to the management process, are unlikely to welcome them with open arms. The doctor in management has a lonely role in some of today's hospitals. Those who have taken this route have found that it is invaluable to have access to other medical colleagues involved in management, for exchanging ideas and information and for mutual support. If at all possible, doctor-managers should build these relationships within their own institutions, and they may also find it helpful to join regional groups and national associations.

What are the rewards?

By far the most important reward of playing a part in management is the opportunity to work on the broader canvas of the organisation as a whole and to have a major influence on the development of a better service for patients. This is the major reward cited by clinical and medical directors, and many find the transition back to a non-managerial role difficult. Indeed, some hospitals have developed other managerial roles for former clinical directors, so that their hard earned experience and skill is not wasted.

In future, management input will probably increasingly be rewarded financially. At present some doctor-managers get extra sessional payments, some get extra clinical support, and some get extra paid leave. Management input is now also one factor considered during the assessment procedure for C distinction awards. However, medical and clinical directors generally believe that the fundamental reward is likely to remain the professional satisfaction obtained from functioning as an effective member of a team having a major influence on the future direction and development of the clinical service.

Business plan

Services description

Activity:

- Case mix
- Numbers
- Sources of referrals

Staffing

Resources used:

- Buildings
- Equipment
- Non-pay items
- Other services used

Monitoring and communication:

- Information systems
- Management structure
- Marketing
- Quality and audit

Finance (based on all the above):

- Income/expenditure
- Capital charges
- Balance sheet

Goals and objectives

Mission statement

Objectives:

- Achievable
- Measurable
- Monitored
- Set time scale

Action plan

(to achieve objectives)

- New developments
- Restrictions
- Financial forecasts
- How monitored