Unusual patterns of start of rheumatoid arthritis

- Palindromic
- Polymyalgic
- Monoarthritic
- Oligoarthritic
- Asymmetrical

Differential diagnosis of rheumatoid arthritis

Psoriatic arthritis—always seronegative
Primary nodal osteoarthritis
Other connective tissue diseases
Calcium pyrophosphate deposition disease

Symmetrical small joint polyarthritis, with or without large joints also being affected, is the commonest presentation. In elderly patients the start of rheumatoid arthritis may be indistinguishable from polymyalgia rheumatica. Occasionally, rheumatoid arthritis may present as a monoarthritis. Other conditions (such as infection, crystal arthritis, other inflammatory arthritis, etc) must be excluded before a diagnosis of rheumatoid arthritis is made.

Palindromic rheumatism is characterised by recurrent episodes of mostly oligoarticular arthritis that leave no residual clinical or radiological changes. Up to half of patients with this condition later develop typical rheumatoid arthritis, often accompanied by conversion to seropositivity for rheumatoid factor.

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The ABC of Rheumatology is edited by Michael L Snaith, senior lecturer in rheumatology at Nether Edge Hospital, Sheffield.

Management for Doctors

Managing change

Peter C Barnes

This is the ninth in a series of articles dealing with issues arising as clinical practitioners increasingly take on managerial roles. The series is edited by Jenny Simpson, chief executive, British Association of Medical Managers

Case study: rationalisation of hospital services

Henford General Hospitals Trust comprises a large teaching hospital, Henford General, on the periphery of the former district and a small hospital, St Judes, in a deprived inner city area. St Judes has served the local population well for over 100 years and has gained an excellent reputation.

Considerable opposition was mounted, unsuccessfully, to the closure of its accident and emergency department several years ago, to centralise the services on a single site at the main hospital. It has been understood for some time that a substantial development at Henford General would, at some stage, lead to the transfer of all services from St Judes and its subsequent closure. As a result, planning blight has afflicted St Judes and staff morale has plummeted.

Henford General Hospitals Trust has recently undergone major management reorganisation, leading to the introduction of clinical directorates, which have now been in existence for two years. Some very clear improvements in service have resulted from this development and the organisation as a whole has adjusted well to the cultural change. Nevertheless, the clinical directors still feel a conflict of loyalties between the needs of individual patients and the needs of the organisation as a whole, particularly when considering the difficult financial circumstances of the trust. Many are disappointed that their successes with efficiency savings have not led to direct benefit to their own services. Escalating costs, continued cost improvement programmes, uncertainty about purchaser intentions, and potential instability with regard to local fundholding general practitioners have all

become part of the daily routine of the management of the trust which is under considerable pressure to balance its books. The regional health authority's plan for a shift of resources within the region using a weighted capitation formula shows that Henford District will be a relative loser and as a result will receive only the minimum increase in annual funding and have less growth money than in previous years. Although the hospital is used to experiencing considerable financial difficulties, the feeling in the main hospital is that crisis point has now been reached.

Early in the present financial year it became clear that the unit was heading for a major overspend that was unlikely to be met by marginal savings within each directorate. A task group was set up to look at the feasibility of an early transfer of all services from St Judes to Henford General to permit the closure of St Judes and the realisation of recurring revenue savings. Before the task group had completed its report considerable opposition to the move was voiced by staff at St Judes, led by two well respected clinicians, the Community Health Council, and members of the public who lobbied MPs and presented a petition objecting to the closure to the health secretary. Board members expressed anxiety that a premature closure of St Judes might lead to service reductions and jeopardise contract income and the future development of the trust. Nevertheless, after consideration of the task group's report which indicated the feasibility of transfer with minimum effect on services, they reluctantly recommended the transfer of services by the end of the calendar year.

Analysis

In the case cited the dilemmas and pressures are obvious and, unfortunately, not unique to the NHS. In recommending the early closure of St Judes and endeavouring to deliver Henford's acute services from a single site, the management board has taken a decision fraught with potential problems. How to

proceed depends on how mature and effective the decision making structures have become since the development of clinical directorates. Whatever the decision, it is unlikely to be one which will command universal approval. In this situation the vital thing is to secure a decision making and change process that is as open as possible. This will not guarantee success but

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will give better prospects. At least those involved should understand what is happening, and why.

An analysis of the situation can be made using a modified version of the Nadler and Tushman diagnostic model (fig 5.1).¹ The organisation is seen as responding to, and in turn influencing, the external environment, and internally it is seen to comprise four components:

- The tasks
- The formal organisational arrangements
- The informal culture
- The individuals.

The use of a such a model will not only allow organisational problems and the need for change to be analysed but will also help to identify areas of potential opposition to the intended changes.

People resist change for many reasons, but some of the most common are parochial self interest, misunderstanding and lack of trust, different assessments of the problems and solutions, and low tolerance for change.

FIG 1—A model for organisational structure and function

CHANGE AND THE TASKS

The tasks are the activities which need to be carried out if the organisation is to meet its goals. Current emphasis on objective setting in the NHS is highlighting the importance of this component, which is the quantity and quality of service provided. It is to be expected that some opposition will be based on arguments about reductions in quantity or quality of service, or both, and it is important that honest and explicit statements are made about the expected impact of the transfer of services. Managers who initiate change often believe that they have all the relevant information required to conduct an adequate organisational analysis and also that those who will be affected by the change are fully aware of the facts. Neither assumption may be correct. Legitimate opposition based on more valid assessments should be given appropriate recognition.

CHANGE AND THE FORMAL STRUCTURE

The formal organisational arrangements include accountability, job definition, and pay structures, and are usually fairly straightforward to describe. The reorganisation and new descriptions of these under the new arrangements is a fundamental management task which should be undertaken at the outset of the change process. While the period of turbulence is at its height and until a new set of organisational arrangements is in place, there may well be resistance which manifests itself in attempts to maintain control through the old formal mechanisms. An appeal from the medical staff committee at St Judes directly to the purchasing

authority or the regional health authority would be an example of this.

CHANGE AND THE INFORMAL CULTURE

The informal culture is less tangible but more enduring than its formal counterpart and is often the life force of the organisation. The power bases of the organisation—who has what influence and why—are a fundamental part of the informal culture, which, at St Judes, will also embrace the long history and tradition of good service. Nevertheless, there has been planning blight and a reduction in staff morale. The informal culture will also include some degree of openness and readiness to change, and a willingness to maximise the benefits that will arise from a clear decision and the removal of uncertainty about the future.

CHANGE AND INDIVIDUALS

Individuals' reactions to change differ because of who they are, how they will be affected, and because their perceptions and knowledge about the change will vary. Medical and other staff may be worried about the dissolution of well established teams in theatre; others may have simpler concerns—for example, about transport difficulties and possible consequences on childminding arrangements. The changes may call for an adjustment in the numbers, skill mix, and experience of staff. Ensuring that individual needs are met in the new arrangements can be a major source of difficulty at times of rapid or enforced change.

CHANGE AND LEADERSHIP

The model also shows the clear responsibility of senior management to shape, define, and encourage a shared vision of a better future. Without this vision appropriate and successful change will not occur.

Managing the change

Having identified the problem, the need for change, and the intended solution, senior management needs to make it happen. The following steps are minimum requirements in managing the change:

- Describing the future
- Publicising the change
- Commitment planning
- Action planning
- Maintaining the status quo.

DESCRIBING THE FUTURE

Given the legitimate anxiety of many people about the nature of the problem at Henford General Hospitals Trust and the perceived reduction in quantity and quality of service that may ensue, it is essential that these issues are clearly addressed with regard to each element of the diagnostic model. High priority should be given to concerns about patient care (the tasks) and what changes are likely in terms of numbers, skills, and attitude (the individuals).

There should be a clear and coherent human resource strategy which takes into account opportunities for redeployment, retraining, and voluntary retirement. For example, redundancies could be minimised by vacancy control in the period before transfer, and the opportunities to form new and better teams should not be overlooked.

PUBLICISING THE CHANGE

As a result of the vocal opposition already mounted, accurate and informed publicity is essential. Much will depend on the reliability and extent of information networks in the trust—for example, team briefing, newsletters, and staff meetings. People should be given

information as soon as possible to minimise rumour and to allow them time to adjust.

COMMITMENT PLANNING

As well as developing the change strategy, the planner has to determine who in the organisation must be committed to the change if it is actually to take place. These key players are then assessed on a scale of commitment:

<i>No commitment</i>	Likely to oppose the change
<i>Let it happen</i>	Will not oppose the initiative but will not actively support it
<i>Help it happen</i>	Must provide resources (time or equipment)
<i>Make it happen</i>	Must be actively involved and willing to lead

People's current positions and where they need to be for the change to occur are charted on a table. The difference between the two is a crude measure of the work which may need to be done to obtain the necessary commitment from the key players (fig 5.2). In charting a person's position a degree of scepticism is sometimes necessary; expressed support is not always followed by appropriate action and sometimes covert resistance is encountered.

ACTION PLANNING

The action plan is a list of all the tasks that will need to be completed for the change to take place. It is the road map of the change process. It is critical that the action plan is realistic and effective. It should be relevant to the change goals; specific; integrated; time sequenced; and adaptable. The task details, start and finish date, and responsible staff should be published and circulated to all involved. In the case of the transfer of St Jude's, up to 100 major separate tasks will probably need to be coordinated. This will involve a large number of people and considerably stretch the organisation's resources.

MAINTAINING THE STATUS QUO

The scale of the changes in Henford make it unlikely that the same volume of work could be accommodated during the change period. This should be explicitly stated so that everyone knows what standards are to be maintained. There can be a perceived status differential, with routine work being seen as less important than the change project, and therefore the support and encouragement of those who are keeping the hospital on target with its clinical work should be recognised and undertaken.

Key players	No commitment	Let it happen	Help it happen	Make it happen
Chief executive officer				OX
Chairman St Jude's medical staff committee	O →	X		
UMB member A		O →		X
UMB member B			O →	X
Consultant C		O →	X	
Consultant D		X ←		O
Manager E		O →		X

O = Present position; X = required position.
(Consultant D has poor interpersonal skills, and his enthusiasm is likely to be counterproductive.)

FIG 2—Commitment chart

Key point summary

- The decision making and change processes should be as open as possible
- The tasks, the informal organisational arrangements, the informal culture, and the individuals need to be analysed
- To make change happen effectively, it needs to be described clearly, publicised, and committed to, and action taken and the status quo preserved
- The politics of the organisation are critical
- Foresight in terms of training needs is essential
- People's difficulties, when faced with change, should be respected, not ignored, and dealt with
- Continuity and tradition should not be destroyed just for the sake of it

Coping with change

Success in change, particularly where professionals are concerned, turns on the ability to face real issues in an open enough manner to allow people to experience a sense of their own ability to influence their own destiny and to cope with the pressures and uncertainties inevitably generated by change. Individuals have four main categories of need amid a programme of organisational change. They need intelligible information. They will probably need to develop new skills, if only those needed to deal with new people as colleagues or supervisors. They will need support to help them deal with new problems. First and foremost, however, is a need for empathy. Pierre Casse defines empathy as follows:

"Empathy is the ability to see and understand how other people construct reality, or more specifically how they perceive, discover and invent the inner and outer worlds. We all use empathy. All the time. We constantly guess what people think and feel. The problem is that in most cases we guess wrongly. We assume that what is going on in somebody else's mind is somewhat identical to our own psychic processes. We tend to forget we are different. Sometimes drastically different. To practise empathy is to recognise and take full advantage of those differences."

Conclusion

To manage changes effectively involves the ability to create a new synthesis of people, resources, ideas, opportunities, and demands. The capacity to create systematic plans to provide for the logistics of resources, support, training, and people is central to any programme of change. People must be influenced, departmental boundaries crossed or even "swallowed up," new ideas must be accepted and new ways of working embraced. The politics of the organisation are crucial. Support must be mobilised, coalitions built, opposition handled, and bargains struck. People will need help to cope with the stress, anxiety, and uncertainties of change. Continuity of tradition must be overturned, in part, as the old is replaced by the new. Yet continuity and tradition provide people with stability, support, and meaning and should not needlessly be destroyed. The effective management of organisational change demands the resolution of these apparently conflicting challenges.

The help of Colin Carnell is gratefully acknowledged.

- 1 Nadler D, Tushman ML. *Perspectives of behavior*. New York: McGraw Hill, 1977.
- 2 Casse P. *Training for the cross-cultural mind*. Washington, DC: Society for Intercultural Education, Training and Research, 1979.