Aside from the many personal tragedies which they cause, premature deaths among able bodied people also have economic consequences. Taking account of that fact, official demographers have calculated data which underline the vast annual loss of labour potential. According to a press report, in 1991 premature deaths accounted for a loss of 2.23 million man years of working life.⁴ That figure included 1.02 million man years lost which were ascribable to deaths from accidents, poisoning, and trauma. Of those deaths, as many as 52.4% occurred in people who were drunk.

Broadening the focus, that report also implicated alcohol in violent deaths and referred to the role of alcohol in aggravating deaths from cardiovascular, gastrointestinal, and other diseases. Furthermore, it drew attention to the deaths of sober people caused by people who are drunk. Overall the destruction of life was such that in 1991 "more than a quarter of the labour potential in Russia was lost in connection with deaths which were caused predominantly by alcohol."

An uncertain prospect

One demographic feature which Russia and the countries of Western Europe have in common is a high figure for the crude death rate. In those countries the figure is high on account of improved life expectancy—

with more people living to old age, an increasingly elderly population results in a high death rate. In Russia, however, the explanation is very different. There life expectancy has fallen, with a substantial increase in deaths—especially those due to trauma and poisoning—among the population of working age. The position is further compounded by rising infant mortality (not discussed here).

These alarming demographic trends, which represent an evident threat to national self interest, have now acquired political relevance and provide political ammunition for Boris Yeltsin's opponents. Whether they will have much influence on his government's policy making in this connection can hardly be determined. However, it seems justifiable to conclude that without an effective antialcohol programme further deterioration in Russia's mortality record may well be reported.

I thank Ian Jeffries for reference 1.

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3 Gosudarstvennyi doklad o sostoyanii zdorov'ya naseleniya Rossiiskoi Federatsii v 1992 g. *Zdravookhranenie Rossiiskoi Federatsii* 1994;3:3-8.

4 Ne dozhil do pensii—ubit alkogolem. *Rossiiskie vesti* 1993;255:4.

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Management for Doctors

Getting the best from people

Andrew Vallance Owen

This is the tenth 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

A surgeon was appointed to a new consultant post in a hospital in the south of England. The advertisement for the post had given little detail and the job description was equally vague, but he had understood, through discussion before his appointment, that he would be able to develop his special interest while in the job.

On taking up the post he found out almost immediately that he had been allocated only one operating list a week when his predecessor had had three. Although he thought he had been appointed to develop a specialist role, little interest was shown in this and, despite his limited access to theatre, criticism began to be made about his developing waiting list. He soon realised that some of his consultant colleagues had been against the establishment of a new post from the start.

The situation slowly deteriorated over the next two years, although during this time he was able to build up a reasonable private practice. In his NHS hospital, he felt that staff were somehow being turned against him, including the nursing staff in theatre who had been asked to report on his attendance and punctuality, although they had never complained about this. He became increasingly

concerned and frustrated over the lack of resources being put into his unit and eventually spoke out on this issue at a public meeting.

Shortly after this he was called in to account to the chief executive and medical director without being given the opportunity to bring a supporting friend. Only at the meeting itself was he given statements that had been written about him—two of them specifically commissioned—containing a number of minor allegations. He was given little chance to defend himself and threatened with the possibility of dismissal if he did not "improve."

At this point he involved the BMA, which sought a meeting with personnel. When this eventually took place the personnel director opened up the completely new possibility of redundancy because of financial cutbacks; she denied that there were any formal or disciplinary charges being made against him. The whole thing had been handled so badly that it was clear he would be able to fight off this threat, but he had, by now, become so demoralised that he decided to resign his post in any case and left the NHS to work in Saudi Arabia.

In the 1950s McGregor described two very different sets of assumptions, which he called Theory 'X' and Theory 'Y'.¹ Theory 'X' assumes that people are naturally lazy, lacking in ambition, and self centred, and that they need to be managed by coercion and control. Theory 'Y' assumes that people are not naturally like this, but if they become so it is due to their experiences; that they are ready to assume responsibility, and getting the best out of them needs management which is collaborative and supportive. Theory 'Y' is the philosophy on which this article is based.

Although details have been changed to preserve anonymity, the case study is based on an amalgam of real experiences in Britain over the past two years. It shows effectively how to demotivate comprehensively a young consultant who was once an enthusiastic innovator, which was done, at least in part, by his own colleagues and other doctors involved in management. There are many lessons to be learnt, but the crucial one is that this is how not to do it.

People need to be motivated to perform well and to stay in the job; motivation, therefore, is one of the key roles of management. Some of the work on this subject

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will be considered in the first part of the article as a backdrop to a discussion on a number of practical issues which are directly relevant to doctors in management.

Motivation

After interviews with 200 engineers and accountants in Pittsburgh, United States, in 1966 Herzberg found that five factors were associated with feelings of job satisfaction and that five different factors had the reverse effect (box).²

Motivating and demotivating factors	
Job satisfaction:	Job dissatisfaction:
Achievement	Company policy/administration
Recognition	Supervision
Work itself	Salary
Responsibility	Interpersonal relationships
Advancement	Working conditions

Many surveys over the years have supported this work and suggested that people work best if they are given a worthwhile job and are allowed to get on with it. Theories abound, particularly relating to human needs. For instance, Maslow described an ascending hierarchy of needs (modified by Aldefer)—the need for existence, the need to relate to others, and the need for personal growth.³ The higher order needs are said to be particularly prevalent where people of intelligence and independence are working on challenging problems, and they act as strong motivators. McClelland described a different set of need categories which included power, affiliation, and achievement.⁴ A large survey he conducted in the United States indicated a particularly strong positive correlation between high need for achievement and high levels of performance.

Handy, however, in describing these theories, questioned whether satisfied workers actually work harder, although he believed that they will tend to stay at work and in the same organisation.⁵ He argued, on the principle of reinforcement, as many do, that it is incentives which lead individuals to increase their efforts. These are not, of course, related to just money but also include promotion, status, and independence among many others. But Handy pointed out that incentives are only likely to work if:

- People perceive the increased reward to be worth the extra effort
- The performance can be measured and clearly attributed to the individual
- The individual wants that particular type of reward
- The increased performance will not just become the new minimum standard.

So, getting the best out of people like doctors must require attention to their individual needs, both for satisfaction and personal growth, and to the sort of rewards that will act as an incentive to them.

Job design

On the basis of his survey work, Herzberg produced a set of principles for job design which included the following:

- Remove some controls while retaining accountability
- Increase accountability of individuals for their own work
- Give the person a complete natural unit of work

- Grant additional authority to the employee in his/her own activity

- Introduce new and more difficult tasks not previously handled.

This type of approach—increasing motivation through increasing individual responsibility—became known as “job enrichment” and has been echoed by several writers. Interestingly, doctors, at least those in the career grades, have had a degree of real professional independence until recent years; their jobs did satisfy most of the above principles, and they were generally well motivated. Unfortunately, the constraints imposed by the NHS changes, the new bureaucracy, and, frequently in hospitals, a management style based on control and coercion (McGregor’s Theory ‘X’) has led to profound demotivation and loss of morale. It is therefore particularly distressing when doctors seek, in addition, to demoralise rather than to motivate their own colleagues.

Well thought out job design is crucial before the advertisement of a post is even considered. Accurate description of jobs, all of which should contribute to an organisation’s effectiveness, is fundamental to the development of an efficient staffing system. The job needs to motivate by taking account of the sort of needs described above. Wall confirmed the potential of this type of approach and showed that, when properly implemented, it can benefit both job satisfaction and productivity.⁶ However, he also pointed out that to ignore implementation issues, such as organisational structure and practice, is to court disaster.

In the case study there was a clear mismatch between the expectations of the sitting consultants and those of the person appointed. No thought seemed to have been given to how the new role would fit with other activity and the general objectives of the division. Were potential medical colleagues properly consulted about the makeup of the job? If not and there was a change that would affect them, it is perhaps not surprising that antagonism developed.

“People need to be motivated to perform well and to stay in the job.”

In this case the job description may have accorded with Herzberg’s principles of job design in giving a degree of autonomy to the consultant, but this was then completely undermined in practice, perhaps because the implementation issues were not considered. When expectation is forcibly lowered in this way, demotivation will undoubtedly follow. Full discussion between those involved at an early stage has a better chance of achieving a job description all can agree with and support.

Appointment

To get the best out of a person, the best person for the particular job should be appointed. Some writers, such as Bowen *et al*, suggest that people should be hired to fit the characteristics of the organisation, not just the requirements of the job, but an organisational needs analysis to fit every job would make recruitment even more complicated than it is already.⁷ Nevertheless, consideration does need to be given to the context of the job as well as the content during the selection process.

As well as a job description it is useful to have a good idea of the sort of person required beforehand. An agreed person specification can help with this, particularly when there are external assessors on the

panel. Ideally this should all be agreed before the post is advertised as the advertisement should be founded on a careful analysis of the job itself and aimed at the type of person described in the person specification.

The selection process should aim to:

- Attract a sufficiently wide field of suitable candidates
- Uphold the organisation's image and reputation
- Be fair and be seen to be fair
- Observe any constraints imposed by legislation or internal policies.

The BMA has produced excellent guidance on good practice in recruitment and selection which, given the increasing scrutiny of appointments procedures, is worth reading.⁸ If the wrong person is appointed, as may have happened in the case study, then the consequences can be both serious and long lasting. Medical managers should evaluate appointments for accuracy of job analysis, effectiveness of methods used, and reliability of selectors' judgments—but, more particularly, they should ensure that their training policy covers support training for appointment procedures: the investment is well worth it.

Giving feedback

How to encourage improved performance is a much debated subject. The job satisfiers and suggestions for job enrichment above will all help to get the best out of people, but external feedback on performance is also necessary to encourage improvement and, if done properly, can increase motivation. The quasi-disciplinary hearing described in the case study, which was used solely to give destructive feedback, was a complete disaster in relation to motivation and probably did not do a lot for performance either.

"Accurate description of jobs . . . is fundamental to the development of an efficient staffing system."

Those who oppose formal performance appraisal often cite Deming, who stated: "It leaves people bitter, crushed, bruised, battered, desolate, despondent, dejected, feeling inferior, some even depressed, unfit for work for weeks after receipt of rating, unable to comprehend why they are inferior."⁹ This can happen particularly when appraisal produces formal performance ratings or is linked to remuneration, but the process need not have these results.

Harper argues for a developmental approach which jointly involves both parties in assessing capabilities and potential and exploring ways in which performance might be improved.¹⁰ Among other things, this should lead to both parties becoming aware of requirements for further training and development. A positive and motivating outcome to the exercise can also be encouraged by goal setting, as long as the goals are clear, jointly agreed, and provide a challenge. Locke and Latham have reported that this can lead to improvements in performance ranging from 11% to 27%.¹¹ But in medicine many seem to find this type of process threatening. There is fierce resistance to appraisal of professional "performance" by lay managers for good reason. But clinical audit is an important type of self appraisal and surely it is time other clinical colleagues—perhaps clinical directors—became involved in giving feedback and agreeing joint goals for the coming year. Peer review is fundamental to medical professionalism and, with proper training for all parties, annual review and goal setting could lead to increased motivation and to better performance.

Performance appraisal is already a strong feature of general management, and if it is approached correctly medical managers should gain much from it. Apart from the motivational benefits described above, this a good time to discuss the organisation's overall strategy, identifying how it relates to the manager's area of work and the part to be played in its implementation. It is therefore important for the organisation and the manager in promoting strategic objectives, encouraging involvement, and developing a team approach.

Pay and performance

Herzberg argues that poor pay can lead to job dissatisfaction, but does good pay related to "performance" lead to improved satisfaction and better performance? This is a controversial issue and could be the subject of an entire article in itself, but to answer the question, as Kohn argues in an article entitled "Why incentive plans cannot work,"¹² rewards do motivate people: they motivate people to get rewards.

"Professional work is notoriously difficult to measure, particularly in relation to effectiveness."

Referring to Handy's four points on making incentives work,⁷ the first requires individuals to perceive that the increased reward is worth the effort. Most doctors believe that they are already making a considerable effort across a wide front for the NHS, so performance related pay would probably have to be used to encourage a change in focus or increased effort in specific areas, to the detriment of others. There would have to be very full consultation on this and, even so, it would have to be a high risk management strategy.

This leads on to Handy's second point about the need to be able to measure the performance to be paid extra for and to attribute it fairly. Professional work is notoriously difficult to measure, particularly in relation to effectiveness, and this would be a major stumbling block. It might further discourage the essential "time, touch, and compassion" and those crucial activities which are difficult to measure, such as innovation, or would leave them dependent on doctors' good will—a fast diminishing commodity. The system would also be seen to be unfair and would lose all credibility if performance was constrained in some way by restriction of the resources required to do the job.

Handy's third point is that the individual has to want the particular reward on offer. When extra pay is the reward there will, of course, be variation from doctor to doctor but, for instance, a substantial number of consultants make a conscious decision not to undertake as much private practice as they could; to them, extra pay may not be a great motivator. The final point is that the increased performance should not just become the new minimum standard; this is self evident and would have to be given due weight by managers when change is almost constant, as in many areas of medicine today.

Bevan and Thompson undertook a wide survey for the Institute of Manpower Studies and found no evidence that improved organisational performance in the private sector is associated with the operation of a formal performance management system.¹³ They went on to argue that, using certain approaches, performance management could reinforce a disposition to short termism and set back organisational effectiveness in the long term. They suggest that for performance management to have any success, emphasis is needed

on development driven approaches, such as those described in this article, rather than on reward driven models.

Complaints and discipline

This is an area where it is difficult to get the best out of people but where it should be possible to be reasonable and fair to reduce the chance of complete demotivation. Huberman argues that self respect is probably the most potent motivator of satisfactory performance and disciplined behaviour, but also suggests that respect for "management" is an important factor so management must do all it can to gain the respect of those "managed."¹⁴ His article, entitled "Discipline without punishment," describes a Theory 'Y' approach which gives each individual every possible and reasonable chance to play a positive and satisfactory part. The case study gives an example of a different type of approach which, while not common, is not unusual—if there are inadequate safeguards in place, it can happen to anybody if someone in authority develops a personal grudge against them.

A discipline policy should cover two main issues: substandard performance or behaviour and litigation avoidance. There should always be a formal discipline policy and this must be fairly applied; it is particularly important to agree performance standards or determine clearly defined work expectations for each job so that all parties can agree when a variance has occurred.

Gossip and innuendo cannot form the basis of any action and should be stopped, if possible, at source if no formal complaints are to be made. Any person about whom a complaint has been made is entitled to know the nature of the complaint and who has made it and to be given the opportunity to respond to it. If there is no substance to the complaint the slate should be wiped clean and the doctor informed immediately.

If the doctor needs to be interviewed or counselled then this should either be done one to one, supportively, and in complete confidence, or if a panel of some sort is to be formed the doctor must be given the opportunity of being accompanied by a friend to the hearing; if this is not done it can appear rather like a "kangaroo court." If after this the matter has to be pursued, formal procedures should be invoked as these have been designed to ensure fairness to all parties. Again, if there is to be no action then the slate must clearly be wiped clean.

These are sometimes extremely delicate issues and bad handling can lead to long term bitterness and demotivation all round. There are often no easy answers but the general approach should follow the old adage "do as you would be done by."

Training and development

Training and development have to be regarded as central to getting the best out of people. Keep promotes the importance of investment in training and development as a test of whether an organisation is treating its staff as a resource or as a cost commodity.¹⁵ Organisations that invest in their staff in this way, he argues, will motivate, retain, and develop them to make best use of their skills and maximise the chances of continuous improvement which will lead to continued success.

This is a massive subject which one cannot do justice to here, but, in general, writers in the field would agree that training must tie in not only with the needs of the individual and the needs of the job, but also with the needs of the organisation which is providing the investment. In medicine there has always been an emphasis on self development; medical managers or clinical directors should facilitate and encourage this,

Key point summary

- Getting the best from people requires attention to their individual needs
- A well thought out job description and an accurate description of the job are essential
- Feedback can help promote strategic objectives, motivate, and develop team work
- Managers need to encourage self development and to provide appropriate training
- Proper structures for support, complaints, and assessment need to be established

but it should fit with the goals jointly identified in feedback discussion. If it does fit then funding should be almost automatic as it should both motivate and improve performance.

Management training is also essential to enable those doctors involved in management to learn how to get the best out of their colleagues. It should cover all the areas discussed in this article and must include communication, counselling, dealing with complaints, and approaches to professional discipline. Unfortunately, in many parts of the NHS there has been an increasing rift between doctors and managers, albeit often promoted by government policies. Both parties need to learn more about each other's philosophies and it may be that more multidisciplinary development work would encourage this. Lack of understanding can lead to antagonism and bitterness, which bring out the worst rather than the best in people; more has to be done to change attitudes and encourage cooperation if care of patients is really to be a team effort involving and motivating all concerned.

Summary

To get the best out of people the McGregor Theory 'Y' manager will be supportive and collaborative rather than controlling. The aim will be to appoint staff to properly designed jobs and to motivate them by working with them and agreeing joint goals, by encouraging self development and appropriate training, and by being both firm and fair. In essence this manager will care about colleagues and see them as a resource to be nurtured rather than competitors to be undermined or costs to be cut. If the doctor in the case study had been treated in this way perhaps he might still be motivated and treating British patients instead of going to Saudi Arabia where he feels more greatly valued both as an individual and a professional.

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