

Doctors, managers and politicians

Graham Winyard

Abstract – Doctors and politicians have rarely seen eye to eye on what a health service should provide and how it should be managed. The introduction of general management in 1984, while initially successful, created new fault-lines between doctors, managers and politicians that were compounded by a succession of NHS reorganisations. These changes brought politics too close to front-line management, highlighted the incompatibility of managerially determined targets with the essence of professional practice, and have led to the development of a management agenda disconnected from healthcare. Remedies are suggested here that reflect the particular roles and contributions of each group that could restore a sense of shared purpose in the running of the NHS.

KEY WORDS: doctors, general management, managers, partnership, politicians, professionalism

Background

Relationships between doctors and managers are currently the focus of much concern, with the vote on the consultants' contract highlighting sharp differences of perspective, and lack of trust. This paper, which is based on twenty years experience at senior level in the NHS and the Department of Health, looks at how relationships between the three 'tribes' of doctors, managers and politicians have evolved over that time. By reflecting on the past, it tries to make sense of the present tensions, and chart a constructive way forward.

The development of general managers as a distinct cadre began in 1984. Before then, although administrators were important, the system in which they functioned was fundamentally different. This was the era of consensus management by teams that included consultant and GP representatives. Within that system, the role of the best administrators was to ensure 'that appropriate procedures, systems and processes were in position to support and enable professionals to deliver care with the minimum of fuss, and see that the organisation functioned in a financially acceptable way'.¹

The philosophy behind consensus management was quite reasonable; namely, that the role of doctors

is so central to the delivery of healthcare that for change to be successful it has to be planned and managed in a way that commands their support. But while the theory was reasonable, the practice was not. Achieving change was invariably slow and ponderous. Decisions frequently represented some form of lowest common denominator, with the potential for inappropriate veto at all stages including by complex medical advisory committees. This approach reached its apogee at the Department of Health, where I first went in 1987. At that time every Department circular with any implications for clinical practice had to be agreed line by line with the Joint Consultants Committee. We would spend hours doing that, to the bemusement and frustration of our administrative colleagues.

And worst of all, at every level, if an agreed way forward could not be found, then nothing happened.

The birth of general management

It was against this background that in 1983 Norman Fowler, the then Secretary of State for Health, invited Roy Griffiths to undertake a review of the use of manpower and related resources in the NHS. His recommendations, contained in a 24-page letter,² focused on the fact that the NHS lacked a general management function.

If Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.²

Key Points

The introduction of general management into the NHS in 1984 provided much needed drive and direction

The subsequent erosion of checks and buffers brought politicians inappropriately close to front-line services

Politics and management are fundamentally different, and in important ways incompatible

The result has been a politically determined, managerially driven agenda that conflicts with professional values and with effective change management

A new balance is needed that properly reflects the particular roles and contributions of doctors, managers and politicians

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He also observed that NHS information systems were inappropriate for focusing on performance, and that professionals, especially doctors, were disconnected from the management of the system even though they were the prime resource users.

By 'a general management function', he meant 'the responsibility drawn together in one person ... for planning, implementation and control of performance.' He commented that 'there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement', which made it extremely difficult to achieve change.

To the outsider it appears that when change of any kind is required, the NHS is so structured as to resemble a 'mobile': designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction.

His recommendations, which were accepted in full and implemented rapidly the following year, included the appointment of a general manager at district and regional levels, and in the Department of Health the Management Executive was created. The tribe of general managers had been born.

There is a very significant irony here: Sir Roy Griffiths did not intend to create an extra tribe at all. In the third Audit Commission lecture, given by him in 1991 when Deputy Chair of the NHS Policy Board,³ he said that he saw the introduction of general management as being about 'the introduction of an effective management process. I did not intend that the result should be yet another profession in the National Health Service to work in parallel with the other professions.' Yet this is certainly what has happened.

General management quickly proved its value, as necessary decisions were taken and previously shelved problems tackled. Hospitals and health authorities were much better placed to tackle difficult issues that demanded radical response. Consensus-shackled inertia would not have been a viable option given the financial and service pressures that the NHS then faced.

Yet today relationships between doctors and managers seem to be at an all-time low. To learn from recent history about what has gone wrong and what we might do about it, it is worth looking at:

- what managers were asked to do
- changes in the structures within which they function
- the generation of a managerial agenda which is disconnected from healthcare.

The establishment of general management made possible the introduction of radical organisational and policy change on a scale and to a timeframe that simply would have been unthinkable before. General managers won their spurs with the implementation of the 'internal market'. They took the Government's conceptual framework together with a few working papers and made the system work in the face of widespread clinical and union opposition. Sir Roy Griffiths' gently spinning mobile had been replaced with a rocket, but a rocket whose direction was not under NHS control.

What is striking, looking back on that time, is the degree of engagement and commitment that there was among managers of all disciplines to make the reforms work. Most privately had major reservations, but they responded to the challenge of being given broad objectives and the space, discretion and resources with which to achieve them. It is sobering to reflect that although today's health policies command far more intellectual support from both the managerial and professional communities, there is nowhere near the degree of personal commitment among managers in their delivery.

Changing the context for general management

When first established, general management was very much part of the overall system of statutory regional and district health authorities, headed by chairmen, that constituted the NHS then. For the next decade, the performance of those authorities was scrutinised against agreed plans. The chief executive was responsible for delivery but it was the authority and its chair that was held to overall account. However, subsequent reorganisations have dismantled most of the buffers between ministers and those responsible for the management of local services.

The last seven years have seen:

- the abolition of regional health authorities (RHAs) as statutory authorities in 1996 and their replacement by regional offices of the Department of Health
- the abolition in 2002 of those regional offices, leaving no management tier between the central Department of Health and strategic health authorities
- the abolition of the NHS Executive as a distinctive part of the Department, with its own chief executive
- the progressive downgrading of the role of chairs and non-executives.

There were no doubt good reasons for each of these changes but their net effect has been the establishment of a managerial chain of command direct from ministers to local chief executives. And the inescapable consequence is that ministerial accountability is now not just for having admirable policies, but also for securing their systematic implementation across the NHS.

Politics and management

In theory, the above structure might be seen as an ideal arrangement. Ministers are the only people in the whole NHS system with any democratic legitimacy, so it would seem logical to have a direct chain of command from them to those responsible for planning and delivering local services. Yet the very different natures of politics and management make problems inevitable.

The reality of Westminster and Whitehall means that the Department of Health is far from being the strategic organisation thoughtfully working out long-term plans that you might imagine as the headquarters of the NHS. Instead it is largely reactive, driven by Parliament and the media to working to very short timescales. Political promotion is entirely a matter of

patronage; criteria for success are unstated and can change by the week at the hands of the media; and ministers can be and are dropped for no obvious reasons without any right of appeal. They carry a colossal workload, working longer hours and ploughing through more paperwork than virtually anyone in the NHS. They are constantly under pressure from every quarter to take action, propose legislation or issue instructions to the NHS. Individuals move on rapidly, so a minister in a particular post has only two or three years in which to make his or her mark. The result is a culture that is risk-averse, that tends to value announcements more than sustained change, and that tends to generate multiple initiatives running in parallel, while being reluctant to look at the cumulative load and prioritise.

All this makes it intrinsically very difficult for a Secretary of State of whatever party or background, even with significant management experience elsewhere, to function as an effective chief executive of the NHS. The job and what is expected of the individual doing it, are very different.

The accumulation of priorities was always a problem, even when these could be confined to statements about what ought to be, ie policies and guidance, with responsibility for implementation lying elsewhere. Regional health authorities played an important role in shielding an under-resourced and pressured NHS from the policy- and priority-making zeal of politicians and the Department of Health. They were eventually abolished precisely because they were seen as barriers to the rapid implementation of government policy, but we are still living with the downside of that decision. The fewer the buffers between ministers and local services, the less the responsibility for implementation can be diffused as being 'a matter for local health authorities'. There is a direct relationship between the highly centralised structure that has evolved, and the fact that there are more priorities and targets than there have ever been, most of which are 'non-negotiable'.

This is a hugely important issue. Politicians will always want to do more and to do it faster than is likely to be possible in practice. They have been elected to make things better. They should be impatient of the practicalities. But the effective management of a centralised NHS requires the setting of real and realistic priorities for the whole system. And sometimes the practicalities are not about dusty old-fashioned ways of doing things, or recalcitrant professional groups, or lack of imagination. Sometimes they represent the realities of achieving change across an organisation as big and disparate as the NHS, particularly when this involves persuading thousands of professionals to change some important aspect of their working practices.

Doctors and managers

Three related issues may help to explain why there is now so much friction between these groups who share many aspirations for developing better health services:

- the management of change in the NHS
- the nature of the targets generated
- the implications of both for medical professionalism.

Making successful change in large organisations essentially entails:

- establishing the case for change in a way that 'signs up' those who will need to change
- motivating everyone involved: changing is nearly always more effort, at least in the short term, than staying as you are
- having sufficient resources (money, trained people, equipment) available.

Achieving the will to change is usually the difficult part, requiring much 'management' in the broad sense of the word: creating the right climate, explaining the need for change, persuading, and converting the recalcitrant. This makes the way in which central policies are developed and targets set particularly important. The more that policies command genuine mainstream professional support, the less effort will be needed to adapt and implement them in any particular locality. Conversely, the more policies and targets are felt to be unrealistic and imposed, the greater the task for local managers in securing their implementation.

An increasing proportion of the targets set for the NHS relates to clinical practice. Everything we know about successful change management would argue for a high degree of professional involvement both centrally and locally in setting, and agreeing, the pace of implementation of such targets. The fact that this does not always occur explains much of the resentment that such targets generate, and the consequent friction between clinicians and the managers charged with implementing targets to 'challenging' timescales.

But this does not explain all of the deep sense of unease that exists around this whole issue. There is something much more fundamental going on here that relates to the nature of professional practice that helps explain many of the deeper frustrations that doctors currently experience. The essence of professional practice is about knowing what to do, or what not to do, in situations of uncertainty. In some senses, real professional practice begins where the guidelines run out. It is captured by the ancient Greek notion of 'practical wisdom' – knowing what to do, which principles to employ, in a particular situation. This was seen as the highest form of knowledge: certainly more important than the technical knowledge of how to make or do something.⁴

*Professionalism is the exercise of discretion, on behalf of others, in situations of uncertainty.*⁵

If the essence of professional practice as a consultant is the exercise of 'discretion, on behalf of others, in situations of uncertainty',⁵ we should not be surprised when those who have been educated to do just that react strongly to being asked to behave as technicians. The more managers are required to deliver clinical targets that doctors do not feel reflect appropriate professional practice, the more likely it is that there will be friction, and the less likely that those targets will be achieved.

What happens then? In the short term some managers lose their jobs, often very unfairly, or distort the figures to avoid

dismissal, not always successfully. A revised contract of employment for consultants offers the chimera of greater control. Market mechanisms start to appear attractive as a means of bringing in more compliant providers, and initiatives arise to replace consultants by other sorts of health workers whose activities are more protocol driven. Neither of these last two stratagems is necessarily wrong or inappropriate; there are all sorts of healthcare interventions that may be best delivered in this way. But what these approaches all have in common is a reluctance to engage in a real dialogue with doctors about what should be done, when it is a concern for precisely that, that is at the heart of doctors' professionalism. Most healthcare does require professionals to exercise 'practical wisdom', so this real dialogue cannot be avoided.

Displacement management

The other reaction to the inherent difficulty of changing clinical practice is to engage in diversionary activities that do not require clinical involvement. Much commissioning, performance managing and business planning falls into this category, but the most alarming aspect of 'management for its own sake' is the serial reorganisation and restructuring that is offered as a remedy for a whole range of problems. This is politically appealing, offering a tangible response, and achieving high-profile change to rapid timescales. But we know, not least from the King's Fund evaluation of the introduction of the internal market, that even the most fundamental set of changes ever seen in the NHS made little discernible difference to the delivery of healthcare.⁶

How little overall measurable change seems to have been related to the core structures and mechanisms of the internal market.

Structural reorganisations have huge potential costs, not least in the way they disrupt the personal networks on which the delivery of integrated healthcare depends. Yet it is this displacement activity which so often preoccupies those managing the NHS, to the bemusement of front-line health workers.

A way out?

Tackling our present predicament depends first on getting real agreement that there is a deep-rooted relationship problem in the NHS getting in the way of achieving what should be shared goals for improving services to patients. This has to be a three-way agreement, including politicians: simply focusing on the doctor-manager relationship, as recent debate has done,⁷ will miss the essence of the problem. Government will have to acknowledge that we will make more, and quicker, progress in improving health services if there is more room for local flexibility and discretion in deciding both what to do and how fast to do it.

The substantial incompatibilities between politics and management need to be recognised. Buffers must be re-established between central politics, which in a tax-funded healthcare system must set the broad strategy and have the last say, and

local management, which needs the space and flexibility to negotiate programmes that can command the broad support of the local clinical community. The core importance of partnership in setting programmes and priorities for the NHS both centrally and locally needs to be re-established.

This does not require further structural change. The split of responsibilities between authorities and their chief executives could be revived. The chief executive would still be responsible for planning and delivery but the health authority, hospital trust or primary care trust board itself would carry the can for deciding what is and is not achievable given local circumstances. The development of foundation hospital trusts with local accountability should reinforce this distinction.

At the same time, we need to re-assess the role and importance of management. On the one hand, we must get away from the fanciful notion that one person, however talented, can turn around a dysfunctional hospital or health system single-handed. On the other, the potential benefits of good management are still underestimated, and undervalued. Recent research from Aston Business School demonstrated a strong correlation between hospital mortality rates and a range of human resources practices, particularly the extent and sophistication of appraisal and team-working.⁸ Good management and managers matter in more ways than we may currently think.

Finally, I suggest that doctors need to become more engaged in setting and maintaining standards. We may chafe, understandably, when managerially and politically set priorities and targets distort clinical practice. But managers are too often left with the task of tackling clinical problems and patterns of practice that should be sorted out by a properly self-regulating profession. There is a whole raft of examples where guidelines on service standards and referral patterns have been developed with full professional endorsement, yet languish unused because of insufficient professional drive to see them through.

At the heart of everything in this article is the notion that the National Health Service will only thrive if we can get a better sense of balance and partnership between doctors, managers and politicians. Achieving this will require difficult change from all three tribes. For politicians and managers, this will involve some restraint, a greater acceptance of limitations of power, and the corresponding need for genuine partnership at all levels in the system. For doctors, this will involve more engagement with the thorny problems of the NHS, and in particular with tackling questions of quality at local level.

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