

# Doctors and managers: building a new relationship

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**ABSTRACT** – There is a long history of problems in the relationship between doctors and managers. The reasons for this stem from the values of each group and the effect that these have on their views on a number of key aspects of healthcare and its delivery. Managers have been seen as the malign embodiment of changes in society and the instrument of the wishes of governments, which are often viewed with suspicion. High-quality healthcare is dependent on a productive partnership between doctors and managers and on doctors being prepared to take leadership roles. Both groups have skills and knowledge vital to the other, so each needs to recognise the strengths of the other and find ways to develop a productive partnership. Clinical work can be improved by the application of management techniques, and management would benefit from more clinical leadership.

**KEY WORDS:** clinical management, doctor–manager relationships, healthcare reform, leadership, morale

Many doctors have good relationships with their managers, but a look at the weekly medical press, the letters pages of broadsheets and other media suggests that there are some significant difficulties. Whilst doctors' views may not be as extreme as those of one British Medical Association (BMA) Junior Doctors Committee (JDC) representative, who considered all the managers she had worked with to be stupid and incompetent, there is clearly a problem with the relationship, and it is neither trivial nor limited to the UK.

A 'divide' between management and medicine matters to patients because well managed care generally produces better outcomes than chaotic and unsystematic care. Whilst patients are generally happy with the quality of the clinical care they receive, they are much more likely to complain about the organisation of care, communication between professionals, the information they are given about their aftercare and other issues related to the way care is organised and institutions managed.

The rift is important to professionals because poor management is likely to damage their ability to work effectively. For society, as healthcare becomes more

and more expensive, there is a legitimate desire to be assured that resources are being used efficiently.

The divide also has a major impact on how policy is developed and implemented. The fact that managers and policy makers have a view of the world and language different from those of many clinicians means that they tend to talk about new policies and ideas in ways that alienate clinical staff. The recent swathe of market-based policies is an example of policies described in terms that are very remote from the realities of front-line work in healthcare. This is important because if a key group of staff, who also are influential within the organisation and wider society, are divorced from the programme to change the NHS, the likelihood of success will be greatly reduced.

## Why is there a divide?

The reasons for the divide between doctors and managers are fairly well understood and stem from the different ways the two groups approach a number of important areas. Managers tend to think in terms of collectives or populations, whereas doctors think about the individual patient. This discrepancy becomes particularly problematic when considering financial issues. Managers are trained to be 'financial realists' who have to consider how resources are spent across the whole organisation. Historically, clinicians do not feel comfortable with the idea that they should view a clinical decision for an individual patient as a resource allocation decision, or that they should consider the potential knock-on effect of each

## Key Points

**Productive partnerships between doctors and managers are essential and the division between these groups is impeding the delivery of healthcare**

**Many aspects of medicine require the exercise of organisational, management and leadership skills and doctors are often not prepared to exercise these skills**

**A new definition of professionalism that sees accountability as the method through which autonomy can be preserved could be an important part of developing a new relationship**

**Too much managerial activity is a diversion from holding a real dialogue with doctors about how care is delivered, the needs of patients met and the requirements of government and tax-payers satisfied**

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clinical decision they make on the resources available to all the other patients in the system.

Managers are trained to think about systems and procedures and, whilst there is some evidence that care delivery benefits from a more systematic approach, for example through managed networks, patient pathways, and structured communication, these approaches do not fit easily with the epistemological and methodological basis of medicine (or other professions). Attempts by managers to introduce systems and pathways therefore can be seen as an attack on the key professional value of autonomy. Management is based on a strong model of accountability upwards, whereas in medicine the model has traditionally been one of autonomy with limited accountability to any third party except in the case of misconduct or extreme incompetence. This means that attempts to improve quality by audit, appraisal and peer review can be interpreted not just as a malign intrusion by those with no business to be doing so, but also as an assault on some of the key values of the profession.

Whilst doctors are still the most trusted of all professions in the UK, it is clear that the historical model of autonomy without accountability is now less acceptable, particularly as the public has become less deferential and much more demanding. This gives a clue to another problem in the doctor–manager relationship. Richard Smith's *BMJ* editorial, 'Why are doctors so unhappy?', and some of the papers that followed, identified a number of changes in society that are leading to a change in the unwritten contract between patients, the public, government and the medical profession.<sup>1–3</sup> Much of this shift relates to reduced professional autonomy, the demand for increased accountability, the decline of deference and the unreasonable expectations being placed on medicine about its capacity to cure all the ills (not only medical) of modern life.<sup>4,5</sup> For clinicians, management has become the personification of many of these changes and is seen as their cause rather than a symptom of a wider processes at work in society. In the UK, management has had the added disadvantage of being seen as the agent of governments viewed as opposed to the medical profession, a point powerfully argued by Graham Winyard,<sup>6</sup> Sir George Alberti and Professor Chris Ham.<sup>7</sup>

The general attack on bureaucracy and the idea that the NHS has large numbers of generally incompetent managers has worsened the divide between medicine and management, particularly as some of the most vocal proponents of this view come from the medical profession. Furthermore, the low regard in which NHS management is held can only serve to discourage clinicians from entering management despite the fact that most of this caricature is inaccurate.

### What can be done?

A study of the differences between the NHS and Kaiser Permanente (KP; a health maintenance organisation in the USA that is based on a group practice model run by physicians) yielded some controversial findings,<sup>8</sup> but two aspects of KP bear closer examination. The first is the development of systematic approaches to care that integrate primary and secondary care,

which is supported by a wide range of evidence about the effectiveness of managed approaches to long-term conditions. The second is the importance placed on a productive partnership between medical leaders and managers. This seems to be enabled by the fact that, whilst individual KP units work within some fairly rigorous rules and targets, there is a high level of local discretion, and agreement about the vision and objectives of its services.

A good manager–doctor partnership within the NHS will require doctors to take on leadership positions, and for this role they will need appropriate preparation, freedom to act and a high level of support for what can be a challenging and somewhat lonely position.

Also, more needs to be done to bridge the divide between the views of doctors and managers.<sup>9,10</sup> Each discipline has an important contribution to make and it would be unwise, and probably impossible, to make one group see the world in the same way as the other. However, there could be greater mutual respect for the important differences in their viewpoints, and how each side behaves toward the other is important in this. Some historical patterns of behaviour, on both sides, need to change.

### Doctors' role in management

It must be recognised that many aspects of medicine require the exercise of organisational, management and leadership skills. Leadership and management are not the monopoly of those who happen to have this label. Running an outpatient clinic, a diabetic service or a consultant firm are major management challenges, and yet clinicians are given little preparation for this role: their learning opportunities are limited to apprenticeship and copying – often from someone who also has had little formal training. This model of medical education is now increasingly viewed as inadequate for clinical medicine. Junior doctors and medical students have little exposure to management and, indeed, little introduction to the idea that they are employees or to notions of accountability. When they do encounter management, the experience is often not a positive one. A short course in management before their first consultant appointment is not enough.

The idea that autonomy is at the opposite end of a continuum from accountability and the use of guidelines needs to be challenged. Autonomy will always be a key part of medicine and needs to be preserved; however, the price of autonomy is accountability. Being able to demonstrate that what was done was effective, that mistakes have been learnt from, that evidence was used and that all other expectations of patients, the public, society and their agents are being met, are the only way to safeguard autonomy. Appeals to 'protected knowledge' or the 'magic of professionalism' will not be enough. Redefining professionalism to incorporate notions of defensible autonomy, making care more systematic where appropriate, the need to depart from guidelines where judgements indicate this is necessary, and accountability for the results and the resources used, would not only improve relationships with managers but also address the perceived crisis of professionalism.

### Management changes needed

Perhaps even more fundamental changes are required of management. Although in general the top tier of management in the NHS is of high quality and compares well with other sectors, most complaints seem to be about junior and middle management. Improvement in capacity and capability at middle and lower management may be needed to help such managers with what is a difficult job – dealing with a front-line workforce that is in general better qualified, often more intelligent and certainly more powerful than they are.

The system needs to allow managers to spend more time nurturing their organisations rather than looking up the management line. Some managers may need to rethink the way they work with clinical staff and the language they use to talk about change, which to clinicians often sounds as if it has little to do with caring for patients. Winyard argues that there needs to be a move away from what he describes, with some good reason, as a politically determined, managerially driven agenda which conflicts with professional values and impedes effective change management.<sup>6</sup> Perhaps his most powerful point is that too much managerial activity, across the developed world, is a diversion from having a real dialogue with doctors about how care is delivered, meeting the needs of patients and satisfying the requirements of governments and taxpayers. Those organisations that do this prosper and so do their patients and staff. Those that do not are doomed to go through endless restructuring, external tinkering and experiments with various versions of the latest big idea, whether that is performance management, managed care or markets.

Above all partnership between doctors and managers is crucial. If this can be achieved, then the prospects for change in healthcare are good; if it cannot, then serious problems lie ahead.

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