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- News: Hospital chief resigns, accusing Monitor of undermining leaders (*BMJ* 2014;349:g6883)
- Careers: Why the NHS needs more doctors to become chief executives (BMJ Careers, 21 July 2014)
- News: Lack of managers is hampering efforts to make NHS efficiency savings, MPs hear (*BMJ* 2014;349:g7459)

Why doctors don't dare go into management

The NHS is keen to encourage more senior doctors to move into management, but few make the leap. Not only is there an "us and them" culture but the risks are far too high. **Richard Vize** reports

The job of NHS trust chief executive almost seems like it was designed to dissuade doctors from applying. It requires a consultant to ditch their job security, probably earn less money, be saddled with problems they don't have the power to solve, and risk public humiliation and professional ruin.

As Hugo Mascie-Taylor, medical director at NHS regulator Monitor and former special administrator at Mid Staffordshire Foundation Trust, puts it, "I'm not saying you have to change the nature of the role, but we have to recognise that as it stands it does not attract doctors."

Russian roulette

The fate of Mark Newbold (see Comment overleaf) exemplifies the risks that doctors take if they enter senior management. In November he was left with little choice but to resign as chief executive of Heart of England NHS Foundation Trust after Monitor had raised the prospect of forcing a change of leadership over waiting times and concerns over mortality rates.[1]

Before entering management Newbold spent 20 years as a consultant in gastrointestinal disease and histopathology. His departure raised the question of why any doctor would choose to surrender their clinical career for the Russian roulette of NHS management, where the average survival time of a trust chief executive hovers around 700 days.

But few doctors are interested in the top job. In a survey of medical directors by Monitor last year just 10 of 106 respondents saw chief executive as a possible career move.[2] Peter Lees, chief executive and medical director of the Faculty of Medical Leadership and Management, highlights the UK's predilection for naming supposedly guilty people when things go wrong as a big disincentive. "This whole scapegoating—taking one person, giving them an impossible job, and then publicly humiliating and sacking them—you don't need to be clever to work out that is not a great recruiting approach," he said. "Do we really want to have a system where we are pretty well alone in the Western world with virtually no doctors going into chief executive roles, when it's often the norm in Europe and the [United] States?" (see box).

With many trusts now in breach of waiting time and financial targets the job of chief executive is increasingly likely to end in failure. Not only are the problems big and growing, but trust managers have limited power to tackle underlying causes such as chronic shortages of general practitioners.

The most obvious route from consultant to chief executive is through medical director. Hugh Rayner, consultant nephrologist at Birmingham Heartlands Hospital, was Heart of England's medical director for medicine in 2000-2009. He says, "I stopped largely because I could see that the problems I had to solve were insoluble. My biggest issue to

Clinical managers worldwide

The number of doctors in management positions in the UK declined sharply in the wake of the landmark report by Roy Griffiths in 1983,[3] which resulted in general managers being put in charge of NHS hospitals despite this not being Griffiths' intention.

A study published by consultancy firm McKinsey and Company with the London School of Economics found that in 2009 just 58% of NHS managers in the UK had any sort of clinical degree, compared with 64% in France, 71% in Germany, 74% in the US, and 93% in Sweden.[4]

Yet there is evidence that clinically qualified managers improve performance. Amanda H Goodall, from the Institute for the Study of Labor, found a strong positive association between the quality of a US hospital and whether the chief executive was a physician.[5] International McKinsey research in 2011 found that a higher proportion of clinically qualified managers tends to improve the quality of management, and better management improves outcomes such as mortality rates.[6] The researchers suggested that clinical training allowed managers to have a better understanding of the processes of care delivery, made it easier for them to communicate with clinical staff, and gave them greater credibility.

Research by the Health Research and Educational Trust in the United States indicates that encouragement is being given to developing clinician managers through new roles such as vice president of clinical transformation, vice president of medical management, and vice president of clinical informatics, which are being filled by doctors as hospitals give clinicians leading roles in reorganising care delivery.[7]

The rewards are high for chief executives in the US. The Harvard School of Public Health found that the average salary for a chief executive of a non-profit hospital is around $600 000 (£400 000; €500 000), and salaries over $1m are unexceptional. Data from the American College of Healthcare Executives in 2006 showed that chief executives were in their posts for an average of 5.6 years.[8 9]

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tackle, which is what brought Mark Newbold down, was capacity and flow, the hospital being overcrowded and overwhelmed . . . The things I couldn't fix were inherently unfixable from one part of the healthcare system."

Double jeopardy

As if the risk of reputational damage and loss of income is not enough, doctors who go into management face what Lees calls the "double jeopardy" of being brought before the General Medical Council. While doctors in clinical practice can face sanctions for errors and misconduct for which they are directly responsible, medical senior managers can face a GMC inquiry for events of which they may have had little knowledge.

Rayner accuses the GMC of having a "blunderbuss approach . . . They fire off these letters to everybody who is potentially involved, [regardless of] whether there is any real evidence that they've done anything wrong, everybody gets sucked in. And you think 'there's this perfectly decent, honourable person who has done all the right things as far as I can see—in other words I would have done the same—getting caught up in this.' It's cruel, intimidating."

Jackie Bene, chief executive of Bolton NHS Foundation Trust, was involved in a GMC process when she was medical director, after an independent investigation into whether deaths at the hospital had been wrongly attributed in the coding to septicaemia. She recalls, "It may not occur to people that there may be that double jeopardy side of things. I was receiving letters from the GMC rather than being investigated by [them] but nonetheless every doctor fears the GMC more than anything. [Getting a letter] sends a chill through your spine."

Niall Dickson, chief executive of the GMC, says that GMC guidance makes clear that doctors are accountable for their actions "even when in roles that could be performed by someone without medical training." But he adds, "We do not have evidence that there is a reluctance to take on managerial roles because of concerns that they could be subject to a GMC investigation if something does go wrong. However, we are aware that some doctors may be reluctant for other reasons to take on chief executive positions—in part this may be because the tenure appears to be short and the post holders so vulnerable."

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Distance from clinical practice

With such insecure appointments, clinicians thinking about senior management roles are acutely aware of the risks of losing their clinical skills. Vijaya Nath, assistant director for leadership at the King's Fund, says that her research has shown that one of the big disincentives to taking a management route is that "there wasn't a path back . . . because of revalidation meaning you have to be so clinically active."

Bene is one of the minority of managers who has maintained her clinical practice. She has been a consultant physician in geriatric acute medicine at Bolton since 1998, continuing her clinical work for more than six years since she was first appointed as medical director. She now does a three hour session every Monday morning on the acute medicine unit.

To manage both roles "you just have to work harder at it. You have to do more reading, make a real effort to keep up with continuous professional development. The challenge is keeping up the current practice—pharmacology etc . . . I do recognise that with the passage of time [professional development] may be a challenge to me and there may come a time when I feel I'm not able to keep up, but that's not the case at the moment." Bene also recognises that it is easier for physicians to maintain their clinical practice than surgeons, where constant repetition of practical procedures is important.

Her clinical work influences her decisions as chief executive, "I can witness at first hand what is happening to patients, so where there are pressures you can see the harmful or negative aspects of the patient experience. It makes you challenge that quite vociferously. That's one of the key contributions of clinical leaders—[to] connect their experience with what needs to happen from the leadership point of view. It's absolutely crucial and something we should nurture. As chief executive you can translate your practice to what should change."

The money matters; it does not compensate for the risk. An experienced NHS consultant who has achieved the maximum clinical excellence award earns around £177 000. That is broadly comparable with many NHS chief executive roles—the main difference being that consultants don't run the risk of losing their excellence awards after 700 days with no job in prospect and their reputation compromised.

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The problem is exacerbated at the medical director level because progression up the excellence awards is interrupted, so spending a few years in management could cost you a lot of money. Nath thinks that excellence awards could be connected to management roles, "There's an incentive there which could be re-harnessed."

Integrated training

Nath also highlights the way Virginia Mason Hospital in Seattle—admired for its quality and safety—has brought management and medical leadership together by putting doctors and managers through the same quality improvement programme. "It was no longer a medical issue or a management issue, it became a quality issue; that helped remedy the culture," she says.

At least among the older generation of doctors management is still caricatured as the "dark side," but medical training, particularly over the past five years, has become more focused on the leadership and teamwork aspects of medical care. With the support of the Academy of Medical Royal Colleges, the NHS Leadership Framework now requires all doctors to develop leadership skills, and a number of deaneries and trusts are integrating leadership and service improvement into training for junior doctors. The effect is that doctors are exposed to the possibilities of leadership and management earlier in their careers and are less likely to perceive such a sharp divide between management and clinical staff. Hospitals are also getting better at explaining management to clinicians, through methods such as buddy schemes between junior managers and junior doctors.

One of the programmes run by the Faculty of Medical Leadership and Management to get doctors into leadership is the Clinical Fellow Scheme, supported by NHS England medical director Bruce Keogh. It provides around 30 junior doctors with an apprenticeship alongside senior doctors in regional and national positions, looking at everything from policy development to research and analysis. Lees has encountered junior doctors who already see management as their goal, "A lot more of them are going to be interested in senior leadership positions, and we've got to make sure they get the skills and support to do that."

Bene says, "I'm hugely encouraged by the junior doctors I come across now. I can definitely sense an enthusiasm for medical management and medical leadership, even to chief executive level. The important thing is to nurture that enthusiasm so it doesn't leave them."

COMMENT: TIME TO TACKLE MANAGERIAL CULTURE

Mark Newbold, former CEO, Heart of England NHS Foundation Trust

Doctors are selected on the basis of their motivation to provide direct patient care, so it will always be a minority that chooses to follow a managerial career. But for those who do, the job of chief executive is a hugely rewarding one to which they can certainly bring highly relevant insight and experience.

Hospital chief executives are often thought to deal mainly with financial or political matters. But the substantial challenges they face are inherently "medical" in nature—for example, the consequences of health inequalities or the impact of the increasing number of people living for longer with chronic illness. We know that managerial actions affect clinical outcomes. At my trust we found that busy periods, with longer waits for emergency assessment and intervention, were associated with higher mortality rates. So effective capacity management can certainly save lives.

These are all matters that doctors are well qualified to manage, and I sense a growing interest in doing so, particularly among young doctors. For those wishing to pursue a career in management, there is plenty of encouragement and opportunity for training, and salaries for chief executives should not deter, as they are now sufficient and comparable to the most senior doctors.

However, there are disincentives for doctors, and in my experience these are mainly related to NHS managerial style and culture. They are not difficult to tackle, and doing so will motivate our non-medical colleagues too. One key anxiety is the harsh, often bullying, performance culture. Doctors are concerned that they may be given unrealistic timescales and judged by narrow and simplistic measures that they cannot always control.

They also fear that short term or political imperatives may place them in a conflicted position. Will they be required to compromise their values? Are safety and quality really the top priorities in the world of senior management? They are trained to analyse and then act on the basis of evidence, and operating empirically can lead to feelings of vulnerability, particularly within a culture where blame is common. I personally experienced an unwillingness to acknowledge the complexity of some problems I faced that was deeply frustrating and a source of disillusionment.

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Tackling managerial culture in the NHS will change the way doctors view senior management roles. Replacing sanction with support, heroic individualism with collaborative working, and central diktat with locally based autonomy would all make a difference. This is not "soft stuff." The NHS managerial style has become outdated in just the same way that Taylorism did many decades ago. Our disappointing staff surveys and the generally poor public view of managers demonstrate this all too clearly.

A practical first step would be to put in place strong and explicit support for newly appointed chief executives. New appointees often arrive during times of crisis, so the pressure is immediate. Doctors coming from a medical career into their first chief executive post should not be left isolated and at risk of sanction for failing to solve problems that are frequently long standing and wider than a single institution.

Richard Vize freelance journalist, London
richard.vize@gmail.com

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