TALKING POINT

Clinicians and management teams

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Since 1974 considerable experience has been gained about the problems of multidisciplinary consensus team work.^{1,2} The present restructuring of the National Health Service now affords an opportunity to analyse this experience, to identify areas of difficulty, and to apply the knowledge and understanding gained during the past eight years in enhancing the effectiveness of the reformed district management teams.

Multidisciplinary team management remains a keystone of the NHS, as does the participation of clinicians in management. The implications of clinical inclusion were not fully understood or appreciated in 1974, but it has become increasingly obvious that there are several issues affecting the clinician's role that are worth examining. Some of these issues arise as a direct consequence of the nationally prescribed team architecture, some derive from inadequate levels of management performance, and others are based on several practical problems associated with the consequence of assuming a dual role.

Many clinicians have been given little guidance in developing their consensus team competence. On the other hand, most of the full-time members of the team have had the opportunity, during the course of their professional careers, to take part in some form of management training. This article explores the major areas of contention in relation to the clinician and his management role and offers suggestions for remedying deficiencies. The term "clinician" encompasses both hospital consultant and general practitioner.

Role of the clinical team members

Three aspects of the management team affect the role of the clinical members: the corporate nature of team work, the structure of the team, and the individual responsibility of the clinical members in the team. A team has been defined as "a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members."³ Many tasks may be accomplished satisfactorily without the need for team work. A team is appropriate when the complexity of the work is such that several people must work together to achieve the solution. Managing the Health Service is complicated and can no longer be performed effectively by any one particular discipline or profession. Each member of the district management team offers a particular skill. A major issue confronting a new team is to distinguish between those parts of its total task that require a joint problem-solving approach and those which can be delegated to individual members, to be dealt with by one particular discipline. For instance, the whole team must be concerned in making policy and planning that determines the future development of district health services, but once it has been decided how much of the annual budget is to be allocated to, say, junior hospital doctors' study leave, this should be delegated to the hospital clinical member to manage in conjunction with his clinical colleagues.

One of the complaints often made by clinical members is

that they think many of the issues are not appropriate to the whole team.

The team's structure militates against effective collaborative decision-making activity. The four full-time officers operate in a different management framework, are occupied in whole-time managerial activity, and relate to their colleagues in a way that differs from the structure in which clinicians work. The officers work in a hierarchical relation with their staff and their team work is an integral part of their total officer function. The clinical members are selected by their medical colleagues and their team role is a temporary one. Are they on the team to represent the interests of their medical colleagues or, once they become full team members, should they be concerned in corporate decision making, the results of which may be contrary to the interests of other doctors? Those who operate as full team members have often incurred their colleagues' displeasure, others who operate as medical representatives only make it difficult for the team to produce the best decisions for the overall health of the district.

Every member of the team has his own professional skill to offer but each is also part of a collaborative group concerned with joint decision making. The team role demands skills and abilities that differ from those relevant to their own particular discipline. This team role transcends that of each individual and is essential to the process of making consensus decisions.

Consensus management

The concept of making consensus decisions is difficult: it demands a climate of openness, honesty, trust, and mutual respect so that everyone may express their views without fear of ridicule, acrimony, or suppression. Consensus cannot occur in an environment of manipulation, lobbying, political manoeuvring, and bargaining. Furthermore, consensus is usually only possible when everyone regards each other as an equal. If consensus operates effectively the final decision is usually of a higher quality and all members of the team are committed to decisions made in this way, even if they would not necessarily have come to that particular solution on their own. Clinicians are not used to working in this way and find it difficult to accept. In a clinical environment the clinicians are the final arbiters in making decisions about patients. Operating the consensus technique demands a particular set of interpersonal and group skills that are not part of medical undergraduate and postgraduate training and which doctors may not possess.

TEAM SKILLS

There are several skills necessary for consensus team work which can be learnt. These include communication, the management of conflict, understanding and dealing with individual behaviour adversely affecting corporate work, decision making and problem solving, leadership, and chairmanship. There is a widespread belief that man is born with these skills, but few people are naturally able in all these areas and even if they are, formal training can enhance aptitude. In

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"Health Services Financing"

BMA's discussion document issued

The 1980 Annual Representative Meeting resolved: "That in view of the failure of the Royal Commission in its report of July 1979 to make positive recommendations to improve the financing of the NHS, the Association should make its own recommendations to Government." During the past two years the Executive Committee of Council has considered ways of improving the financing of the NHS. A progress report was made to the 1981 ARM. The Representative Body was told that the Executive Committee had set aside many of the more commonly advocated proposals for generating extra funds and had examined a system based on insurance contributions supported by exchequer funding, drawing particularly on the experience of other European countries in funding their health care.

The Executive Committee has now prepared a discussion document, which has been circulated to BMA divisions, craft committees, and members of Council. The Executive Committee will consider the comments received later in the year. The discussion document's conclusions are set out here.

Conclusions

The most likely source of extra money for the NHS is an improvement in the nation's economic health. The European experience suggests that switching to insurance funding would not necessarily increase spending on health care, and in any case improvement of the Health Service is not simply a matter of increasing real expenditure on health care. It is particularly important that the funds necessary for the NHS be both identifiable and suitably protected against inflation. Furthermore, the Service will have to use its resources more effectively, and some acceptable form of restriction will have to be imposed on demands for health services.

Alteration in the existing method of financing the Health Service would not necessarily generate extra money for the NHS though administrative costs of an insurance scheme would probably be higher; other ways in which *additional* finance could be raised (lotteries, voluntary fund raising, etc) would add only insignificant amounts to the NHS budget.

Some publicly acceptable way of controlling demand is needed: at present, an unacceptable burden is carried by doctors, who often have to decide "priorities" at the bedside. However, hotel charges or item-of-service payments would not meet the criteria of public acceptability in the view of the Executive Committee of Council.

The increased cost of caring for the aged and the mentally ill and handicapped is being met at the expense of other parts of the NHS, notably the acute sector. If these other parts of the NHS are to continue to be deprived of their share of the small increase in public expenditure on health, some other means of providing the necessary resources will have to be found and it is most likely to be found in developing the private sector.

An increase in the private sector could be encouraged by tax relief on premiums and the provision of NHS drugs and appliances for private patients. But the private sector should not be allowed to develop in such a way that it could damage the NHS.

Decisions on priorities, which result in expansion of Health Service manpower—the single most expensive item in the NHS budget—must be planned carefully, and the necessary resources provided and protected against arbitrary Government measures such as cash limits.

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general, most people working in management teams require training in team skills to perform their corporate task adequately.

PRACTICAL PROBLEMS

Several practical problems may affect the clinician in his team participation—the problem of geographical separation from the officer members, the clash of clinical and team commitments, the paperwork preparation for team meetings, and the emergency demands that may divert the clinician from his management team work.

TEAM TRAINING

The issues discussed here may be solved to a great extent by paying conscious attention to team development. There is a great deal of literature about teams and team training,⁴⁻⁷ which is relevant to NHS management teams. Teams do not just happen, they require help to become effective. The type of training will depend on the particular requirements of the team, but there are two main alternatives: self-development and/or expert assistance from a team development consultant. There are at least two practical manuals available which are written specifically for teams who wish to take a do-it-yourself approach and which are easy to follow. These manuals identify the various blockages that may inhibit team work and offer practical ways of obviating them.^{8,9}

If a team thinks that it requires the guidance of someone who has some skill in team training then it is possible to acquire the advice and guidance of such a person, though expert knowledge in this subject is relatively scarce. A team development consultant possesses the skills that enable him to diagnose

the major problems besetting the team and will be able to guide the team through a logical process of development. It must be borne in mind, however, that whichever developmental process is chosen team building is a long-term process and even when the team is working at maximum capacity and effectiveness it must constantly review its activities and refresh itself. Conscious team development enables team members to develop the skills and attitudes conducive to corporate decision making and allows the team to become an effective and creative working group. Individuals working in teams also benefit personally from participation in team development programmes. Clinicians who have taken part have commented that this aspect of team training helps other aspects of their clinical work.

References

- 1 Eskin F, Nichol JB. Team development in the National Health Service. In: Ottaway RN, ed. *Change agents at work*. London: Associated Business Press Limited, 1978:22-43.
- 2 Eskin F, Nichol JB. Developing team skills. *Health and Social Services Journal* 1978; September 15:1036-8.
- 3 Beckhard R. *Organisations, development strategies and models*. Reading, Massachusetts: Addison-Wesley, 1969:3.
- 4 Wise H, Beckhard R, Ruben I, Kyte AL. *Making health teams work*. Cambridge, Massachusetts: Ballinger Publishing Company, 1974:27-61.
- 5 Tichy MK. *Health care teams*. New York: Praeger Publishers, 1974:79-143.
- 6 Dyer W. *Team building issues and attitudes*. Reading, Massachusetts: Addison-Wesley, 1977:17-24.
- 7 Brill N. *Teamwork: working together in the human services*. Philadelphia: J B Lippincott, 1976:134-45.
- 8 Francis D, Young D. *Improving work groups: a practical manual for teambuilding*. San Diego: University Associates, 1979:57-118.
- 9 Francis D, Woodcock M. *Organisation development through teambuilding*. Mansfield: Challenge Ltd, 1981:118-57.

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