Doctors and general management

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Since the Secretary of State announced in June¹ that the government had decided to implement the recommendations of the Griffiths report² events in England have moved apace. Most regional health authorities have appointed their general managers and districts are well advanced down the same path. Attention will soon turn to the appointment of unit general managers—the level where the most immediate effects on clinicians are likely to be felt. The BMA and the Department of Health and Social Security have now agreed interim arrangements for clinicians, which include remuneration for work as unit medical representatives, and also for doctors who undertake a general management role.³ This has opened the way for doctors to participate in general management and, indeed, to take the lead—particularly at unit level.

Before looking at the problems and opportunities at the level of the unit there are one or two aspects of the emerging national, regional, and district pictures that merit examination.

National and regional level

Curiously, the deadline of the end of September set for regional health authorities to appoint their general manager has passed with no news of the appointment of the DHSS's equivalent—the chairman of the National Health Service management board. This continuing vacancy at the top may explain, in part at least, the impression of ad hoc rule making that accompanied the regional appointments. Some regional health authorities got off to a brisk start and appointed their general managers without benefit of external assessors or outside competition. A second group (acting on hastily issued advice from above) used external assessors, and the remainder combined external assessment with open advertisement and competition between candidates from inside and outside the NHS.

It is difficult to know what influence, if any, doctors as a whole had on these appointments, the procedures for which were going on through the summer in parallel with BMA negotiations over the participation of doctors generally. In the event, out of the 12 regional appointees announced by the end of October, only one was a regional medical officer.⁴ Both the BMA council and the Joint Consultants Committee have since expressed concern over the future role of regional medical officers and whether their special relationship with consultants is to be altered by the advent of a non-medical general manager.⁵ ⁶

District level

District general manager appointments have been or are now in process of being made in the 190 or so districts in England. Again, there is considerable variation in procedure. At one extreme some authorities are selecting a member of the district management team with little or nothing in the way of formal assessment. At the other end of the spectrum several authorities

are applying rigorous selection procedures to a field of internal or mixed internal and external candidates, using specialist executive recruitment agencies. This plurality of approach is in many ways welcome in a service that has become inured to and dependent on rigid central prescription by the DHSS and by Whitley councils over the past 30 years.

These differences over selection procedures have a deeper meaning, too, in that they probably reflect the attitude of the authority to the whole question of general management. It is reasonable to assume, for example, that those wishing for minimum change are unlikely to indulge in extensive selection procedures. While this philosophy may be superficially attractive to clinicians it does not bode well for the success of the exercise in their district. David Bolt's words are relevant here: "If, however, the objectives of the changes—in terms of more resources being directed to services for patients—are to be achieved, consultants must cooperate in the exercise and help the new manager in every way possible. I believe that it is in the patients' interests that the objectives of this management reform should be achieved, and the needs of patients must be paramount in the minds of consultants."⁷

When judging, advising on, or even applying for general management appointments it is vital for clinicians and others to recognise that these are totally new jobs. General management is emphatically *not* the job description of the district administrator written in different coloured ink. A district general manager has quite different functions from those of any existing district management team member. This fundamental point was neatly illustrated in a recent conversation between a general practitioner representative on a district management team and an administrator. The latter expressed the view that if administrators did not become general managers there was no job left for them. The reply of the general practitioner was, "If I were general manager I would not want to do your job—I would be there to make sure that *you* did your job."

POSITION OF CLINICAL MEMBERS

The radically different role of the general manager will inevitably affect the functions of the district management team and its members as well as the rest of the district. The position of the clinical members is absolutely secure in that it is inconceivable that any district will exclude them from the management table. But other members—district medical officer, district nursing officer, district treasurer, and district administrator—will find their roles changing to a greater or lesser extent. For example, if nursing is to be managerially responsible to general managers in units what role is left for the district nursing officer? This is causing considerable anxiety among nurses, and there are problems in other disciplines, but a Canute-like wish for minimum change is not the answer. Neither is some botched up compromise creating expensive non-jobs.

Fortunately, several districts recognise this and, with the help of their chief officers, are taking a more imaginative and positive line. To varying degrees this means a move away from the discipline based district management team towards functional heads or "directorates." Broadly, important functions like finance and other resources; personnel and industrial relations; and planning and information are being grouped under a chief officer who may come from any of the district management team disciplines. In this way the management "board" will come to resemble the top management structure of most

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companies, with a welcome reduction of duplication of function and an increase in accountability of individuals for success or failure. Moreover, the communication and comprehension gap that often exists between district and units will be narrowed by the inclusion of unit general managers as members of the "board."

A further interesting area is opened up for speculation by the likelihood that some general managers at district and possibly regional level will be recruited from outside the NHS. The argument for broadening the field is a familiar and persuasive one—namely, that there is a common core of management skills and experience equally applicable in industry, commerce, and the public service, and that interchange should be encouraged. While proponents and opponents will no doubt quote the careers of, say, Sir Michael Edwardes or Mr Ian McGregor in support of their respective positions, one thing is certain—the learning curve for newcomers to the NHS will have a very steep slope indeed. Stories are already circulating of preinterview cocktail parties (the "trial by sherry" beloved of some authorities) at which able and experienced managers from industry have been rendered speechless by the volleys of incomprehensible acronyms flying round the room.

Unit level

The philosophical differences already described will persist down to unit level. There is, however, an important difference here. It is not too late, as it now is in most cases at district level and above, for clinicians to exert a decisive influence. Regardless of whether the district health authority is inclined to minimum change or more radical restructuring, the opportunity beckons for clinicians to undertake the general management of units.

Units providing acute services are perhaps the most obvious candidates for medical general management. They contain the majority of the consultants working in a district, have the largest budgets, and often exhibit the greatest stresses between clinical imperatives and financial constraints. Who is better qualified to manage and control these than an experienced clinician with a knowledge of the aims and pressures of clinical practice? The task is no sinecure, of course, but most districts contain respected clinicians (senior and not so senior) whose managerial skills have already been sharpened through membership of unit teams, the district management team, or the health authority. Neither need the job terminate a clinical career. In the case of most units, given a continuation or slight strengthening of the existing administrative and nursing management support, part time general management can be combined with some clinical sessions. Similar opportunities for general

practitioners and community physicians should not be neglected—especially where community units exist.

There is another related issue that will need to be resolved by consultants and general practitioners in every district as soon as possible. Whether or not a doctor is appointed, clinicians in all units will need to ensure that timely, balanced, and expert medical advice is readily available to the unit general manager. This will require a re-examination of existing advisory machinery, whether it be medical staff committees, "cogwheels," or LMC subcommittees. In many cases current arrangements will not meet the new circumstances. Moreover, any new system for feeding advice to unit level will need to dovetail with arrangements for advice at district level—preferably without further increasing the medical committee burden. In short, the profession must revise and simplify its advisory machinery in districts to match the new structures and to ensure that its voice is heard.

A great deal at stake

If clinicians fail to take up these opportunities, particularly at unit level, the consequences for the profession are likely to be profound, because there is more at stake than many may think. The philosophy and practice of general management has probably no more than five years to prove itself by improving resource use and patient care at unit level. The brutal truth is that, for a variety of reasons, there will be many inside and outside the NHS who will not wish to see general management succeed. I hope that doctors are not now among that number. On the alternative assumption that it *will* succeed there are yet others who will wish to limit the participation of doctors. To counter both these moves the profession should now be looking to provide not just one or two token candidates but successive generations of general managers, extending the base from units to districts and, ultimately, perhaps even to regions. The opportunity exists for the extension of medical leadership in the NHS in managerial as well as clinical terms. It will be a tragedy if the profession does not seize it.

References

- 1 Department of Health and Social Security. *Health services management. Implementation of the NHS management inquiry*. London: DHSS, 1984. (HC(84)13.)
- 2 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 3 Anonymous. Doctors in NHS management. *Br Med J* 1984;289:1014.
- 4 Timmins N. Ministers push for outsiders in top health service jobs. *The Times*. 1984 Nov 6:2 (col 2).
- 5 Anonymous. Council worried over future of RMOs. *Br Med J* 1984;289:1016.
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THIRTY YEARS AGO

In 1951 the Representative Body of the Association resolved that medical practitioners approached to broadcast either in sound or visual programmes should insist on anonymity as part of the contract. This is the present policy of the Association.

Definition of Anonymity

The Representative Body in 1953 approved the Report of Council on Indirect Methods of Advertising. Anonymity in broadcasting was defined in this report as "withholding the publication or announcement of the practitioner's name, or any information, such as particulars of the appointments he holds, which might enable the public to identify him. Identification cannot be completely excluded, but it is incumbent upon medical practitioners who take part in sound or television programmes to ensure that the possibility of identification and publicity is reduced to a minimum." The report continued: "Unless a practitioner insists on anonymity he is not only offending

against the ethical principles of the profession but is placing himself in danger of being accused of violating the *Warning Notice* of the General Medical Council. Should a practitioner, while carefully observing these precautions, be recognized by a section of the public, that fact should not of itself be regarded as evidence of an infringement of the rule of anonymity."

Ethical Committee's Reminder

Recently the Association's Central Ethical Committee had brought to its notice instances where medical practitioners had permitted their names, and in some cases their appointments, to appear in published broadcast programmes or to be announced over the air. On the instructions of the Committee the policy of the Association was brought to the notice of the medical practitioners concerned, and assurances have been received that in future anonymity in such matters will be required. (*British Medical Journal* 1954;ii:245).