TALKING POINT

Griffiths: A retrospective view from 1990?

TONY WHITEHEAD

In 1984 a Mr Griffiths, from Sainsbury the grocers, discovered a management structure for the National Health Service. It was not a new discovery since variations on this theme have always applied to British industry and are used, for example, in the management of the armed services, the police, and the fire service. Within the hospital service the all powerful medical superintendent of the past was the epitome of a Griffiths type manager.

Mr Griffiths was keen on line management, the managers having powers usually associated with dictators. There was to be a top manager of the board with a lower manager at each region, a little lower manager at each district, and an even lower manager at each unit within that district. Each would be responsible to the one above, except that chairpersons of districts and regions would also participate in the power game.

There was much talk of encouraging doctors and nurses to become managers as if management was an unskilled trade open to anyone with dictatorial tendencies. It was not possible, however, to be a manager and at the same time a practising doctor or nurse, so only the wrong professionals became managers.

Too democratic and costly

The trouble with the health service at that time was that it had become a little too democratic and was also rather costly. Mr Griffiths's answer to the problems of the NHS was a sign of the times, with "leadership" all the rage and any concern for consensus, team management, and worker participation dismissed as absurd if not downright indecent.

Authoritarian systems do have advantages in that decisions can be quickly made and ruthlessly carried out. There is also a clear chain of command and responsibility. All this was, of course, rather attractive to those blinkered politicians who saw cost effectiveness as the panacea for all the country's ills. Unfortunately, authoritarian decisions are often wrong, ruthlessness rarely helps people, and a chain of command and responsibility lead to self protectionism and cover ups. Most of the scandals in our old time mental hospitals were due to cover ups, fear of those above, and the pecking order phenomenon.

Although the system of line management is not necessarily authoritarian, in reality it always tends to be so. Big boss tells the lower boss what to do and he, or she, either carries out those orders or puts their future in jeopardy. Problems in the lower managers' domain must be hidden from the one above and hence cover ups and deception become the normal way of life. In the old type authoritarian mental hospital the charge nurse or sister always tried to tell the one above that everything was in order. This did not usually represent the truth and certainly did not encompass the patients' interest.

Multidisciplinary groups

Of the many different disciplines in the health service, the three largest are medical, nursing, and administration. Long ago, in the 1960s, several progressive medical superintendents of mental hospitals realised that the management structure was not only unsatisfactory in its authoritarianism but that it also mitigated against the multidisciplinary nature of the hospital and the work that it had to do. Out of their dissatisfaction was born the concept of team management. This reflected a multidisciplinary approach to psychiatry and the combination of multidisciplinary management, multidisciplinary clinical psychiatry, and the creation of a network of consultation and worker participation in management. It was a system that markedly improved the psychiatric services. Later, in 1974, the whole health service mimicked psychiatry by establishing district management teams and unit management teams.

Psychiatric divisions extended this principle in various ways. In Brighton, for example, we established a system by which each section of the mental health service in the district had its own multidisciplinary management group relating to both a total staff group in that unit and the unit management team. In this way everyone had a say in what was happening and could initiate new ideas and new approaches to treatment and care.

In Brighton the establishment of the Griffiths management pattern would have—or rather it could have—destroyed all this, but the patients and staff there were fortunate that the district manager and the unit manager approved of the team approach and continued to use the system that had developed. They allowed management by multidisciplinary consensus to continue in the Griffiths era but at the same time accepted the responsibility of management and were able to make quick decisions when these were necessary.

As a result Brighton had the best of both worlds, and the district developed the most effective and efficient service possible with little friction and with staff working together towards mutually agreed targets. Interprofessional disputes disappeared and there was no longer any talk of "them" and "us." Patients were treated humanely, effectively, and at an amazingly low cost effective price.

So in 1990 we can say with satisfaction, though not with smugness, that the marriage of authoritarianism and democracy has worked. Brighton is now an example for those districts where managers rule and the health professions are hard put to get their opinions heard, let alone acted on.

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Associate members unhappy with BMA's services

Strong criticism of the services provided for medical student members of the BMA by the association and by BMA Services surfaced at the meeting of the associate members group committee on 13 April. BMA Services had produced a package of benefits—for example, insurance, mortgages, and loans—but several speakers reported difficulties in being able to take advantage of these benefits. The deputy chairman of the committee, Mr Christopher Valentine from Leeds, who chaired the meeting, said that he had been waiting six months for a car insurance claim to be settled. Another member had been waiting four months.

A representative from BMA Services, Mr John Bennett, advised students who experienced a problem to contact their local BMAS office. Mr Valentine said that he believed that medical students, particularly those in their final years, were a good financial risk as they were guaranteed their first year's job. A meeting will be arranged between the chairman and the managing director of BMA Services to try to iron out the problems.

The industrial relations officer from North West Thames, Mr John Deval, reported on the services that the BMA could offer to students. He said that a guidance note would be produced to help those students who needed to claim supplementary and housing benefits to boost their grants. Industrial relations officers and regional officers were always prepared to talk to student groups, and the possibility of local associate members groups was being investigated. The BMA could represent students at disciplinary hearings and it ran contract clinics in the final years so that students knew what to expect in their first job. The association also looked sympathetically at requests to help sponsor such things as rag weeks and student balls.

Motion to ARM

That was all very well, but with active medical societies some medical schools would be hard pressed to persuade students to join the BMA, was the comment from several regions. Although the associate members group committee claimed to represent all medical students, Miss Fiona Lecky from Manchester believed that the BMA was interested only in the clinical students. Associate members, speakers pointed out, paid £13·20 and this would soon increase to between £13·80 and £14·20. They received *BMA News Review*, but this was of little relevance to most of them, and only students in their clinical years (normally the last 33 months) received the compact edition of the *BMJ*. Not many people thought that the suggestion of local associate members groups was a good idea.

The committee incorporated its feelings in a motion for the annual representative meeting. It believed that though the BMA sought to represent all medical students the package for associate members was not attractive enough and was most unattractive in the preclinical years.

The comments were not all negative, however. The onus was on the existing associate members, the chairman pointed out, to publicise and promote the group into a viable representative organisation. After all, the only alternative was the National Union of Students, which had done nothing for medical students for 10 years.

The committee has submitted two other motions to the representative body:

"That this association advises that no one should participate in a drug company trial that has not been subject to approval by an independent ethical committee for clinical research."

"That this meeting opposes the suggestion that general practitioners should be allowed to advertise."

Shortfall in clinical students' grants

The committee has agreed to keep up the pressure on the government to rectify the shortfall in grants suffered by medical students in their clinical years, who work, on average, 46 weeks a year. In February a delegation from the committee, led by the chairman of council, Dr John Marks, had met the Under Secretary of State at the Department of Education and Science, Mr Peter Brooke. There is a deficit of about £5 a week and the delegation had asked for a flat rate to resolve the discrepancy. But Mr Brooke had said that the only way that clinical students would receive more would be at the expense of other students. In a subsequent letter to the BMA secretary Mr Brooke said: "It would, of course, run contrary to the principle of the mandatory awards system of equality of treatment for all students, irrespective of their chosen course of study, to pay higher awards to clinical medical and dental students alone: to pay the increase to all of those studying for 45 weeks or more might cost £1·5m-£2m a year."

There was a short discussion on the report of the Advisory Committee on Medical Manpower Planning (6 April, p 1088), though without the full report it was decided to defer a full debate until the next meeting. The majority of the professional members on the advisory committee had agreed with the policy of the BMA that medical student intake should be reduced to below the 1979 level, but no recommendation had been made.

The chairman did not believe that the committee could represent all medical students and approve that policy, and he persuaded the committee to pass a motion opposing it. Several members thought that the subject was a matter of personal opinion and a political decision and abstained. Should medical graduates automatically expect to have a job at the end of their course, Miss Judith Smith from Leicester asked, because no other graduates did.

At the request of the group committee the BMA council has agreed to "explore the possibility of establishing a fund for the purpose of financially assisting students who want to pursue medicine as a second degree." The BMA's under secretary, Dr Frank Wells, reported that at present the trust deeds of the BMA's existing charities prevented this as any money covenanted or donated had to be used for doctors or their dependants. Money would have to be sought for a new charity. Dr Wells was optimistic that a new fund could be set up and he agreed to keep the committee informed.

The BMA is running a conference for medical student editors on 22 May. Two delegates from each medical school will be sponsored and editors of medical school publications who have not applied should contact the BMA as soon as possible. Six prizes totalling £500 will be awarded to the best journalists and the best medical school journals.

NHS management board members

The Secretary of State for Social Services has announced the following members of the NHS management board, which is chaired by Mr Victor Paige.

Mrs G T Banks, under secretary, DHSS, is director of health authority finance.

Mr M J Fairey, chairman of the Health Service Information Advisory Group, is director of planning and information technology.

Mr Cliff Graham, under secretary, DHSS, is director of health authority liaison.

Mr G A Hart, deputy secretary, DHSS, is director of operations.

The director of financial management and the director of personnel have not yet been appointed.

The aim of the board, which is accountable to the Secretary of State, is to give leadership and monitor performance to secure improvements in services to patients and more effective use of resources.

The Secretary of State, Mr Norman Fowler, chairs the Health Services Supervisory Board. Its members are the Minister of State for Health, Mr Kenneth Clarke; the Parliamentary Under Secretary of State for Health, Mr John Patten; the Chief Medical Officer, Dr E D Acheson; the Chief Nursing Officer, Mrs Anne Poole; Mr Victor Paige; and Mr Roy Griffiths. The Chief Medical Officer and the Chief Nursing Officer also serve on the management board.

NHS policy board in Scotland

Under the management arrangements in Scotland a health service policy board was proposed and this met for the first time on 10 April, under the chairmanship of Mr John MacKay, Minister for Health and Social Work. The board comprises senior officials of the Scottish Home and Health Department, the chairman of the Health Services Planning Council, the chairman of the Scottish health board chairmen's group, and the Chief Scientist. It is proposed to include two additional people with private sector experience of management in areas related to the various operations of the NHS.

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