TALKING POINT

Griffiths and professionalism

DAVID S GRIMES, DAVID ALLEN

The 1974 reorganisation of the National Health Service strengthened professional hierarchies. All health authority employees were responsible to one of the professional officers, who in turn were responsible to the health authority. Medical staff had a similar arrangement, being represented by rather than responsible to the consultant and general practitioner on the management team.

All this is changing with the present Griffiths inspired reorganisation of the NHS. Although the district and regional officers will retain professional responsibility for their professional subordinates and have direct access to the authority on professional matters, all authority employees will be managerially accountable to the district general manager—assuming that it is possible to separate managerial and professional responsibilities. Once the managerial relationships are removed, however, the justification for the current professional management structure disappears.

Health authorities are establishing directors of various functions—planning, personnel, finance, etc—as district staff and then unit general managers as operational heads of each unit. Organisational design is an exercise in compromise: specialisation is required to allow greater efficiency but it is undesirable to have so many units that they cannot be co-ordinated. “The beginning of administrative wisdom is the awareness that there is no one optimum type of management structure.”¹ Even so, things should be done at district level that are best done at district and things should be done at unit level that are best done at unit.

The aim is to produce the most effective organisation, but what are the criteria of effectiveness? Doctors and other professional groups tend to view effectiveness by the speed and thoroughness with which the organisation responds to the demands of the local community that present to the professionals. On the other hand, the Griffiths proposals give the NHS a line management structure that is designed to make the NHS more responsive to central control rather than local initiative. It is this inherent conflict in the Griffiths structure that is likely to alienate doctors and other professional groups from a management reorganisation that is instinctively more attractive to administrators than to their professional colleagues.

It is important for the general manager to concentrate on his job (whatever it is) and disassociate himself from his previous function (whatever it was), particularly when he has been appointed within his own authority. The general manager needs

to be replaced in his previous function, although whether he needs to be replaced by someone at the same level is not clear, which says something about all the chief officer posts. Whatever their titles, in practice they will no longer be chief officers as they will be managerially responsible to the general manager.

Although the general manager will hold the purse strings, the treasurer's function will probably not change all that much. He will continue to have a professional responsibility for advising the general manager and will retain authority on financial matters, monitoring the budgets and providing information and advice. The medical officer will continue to have statutory responsibility for public health matters and to provide the general manager with advice on preventive medicine, epidemiology, health promotion, and community medicine. He will, however, probably lose responsibility for paramedical professional groups. Most general managers appointed have been district administrators, but it is hard to judge at this stage whether an authority will require an administrator in addition to the general manager to take on the coordinating role that he has hitherto performed. Somebody in senior management, however, will have to be responsible for industrial relations, planning, handling complaints, and servicing the authority.

District nursing officers will probably face the greatest change. At present all nurses are responsible to the district nursing officer, but in future nurses working in the units will be responsible to their unit director of nursing services, who in turn will be responsible to the unit general manager. What will be left for the district nursing officer to do—maintaining professional standards and providing nursing advice to the authority general manager? This is rather a weak role similar to that of the area nursing officer in the pre-1982 administrative structure.

Medical representation

An important aim will be to interlock the medical representative machinery with the new general management structure. Strong clinical participation will be essential at all levels but this need not take precisely the same form as at present. Each unit management group will continue to have a medical representative, and in some cases this person will be the unit general manager. The Griffiths model is constructed round a strong line management structure that passes from the central health services board through the regions and districts ultimately to the unit general managers. Paradoxically, however, the line management stops short of including clinicians, who are the main providers of services and therefore the main determinates of how resources are used.

Another aspect of the relation between management and clinicians that remains unclear is the method of relaying professional advice. The advisory machinery in the pre-Griffiths NHS worked with variable effectiveness. In the new system a strong advisory machinery whereby doctors and other health professionals can make their collective views known to

Blackburn Royal Infirmary, Blackburn, Lancs BB2 3LR

DAVID S GRIMES, MB, FRCP, consultant physician

Health Service Management Unit, Department of Social Administration, Manchester M15 6PB

DAVID ALLEN, BCOM, PHD, senior lecturer in health services management

Correspondence to: Dr D Allen.

management and to the health authority is necessary, even if clinicians are widely integrated into management at unit level. If clinicians are excluded from or shun management responsibility such advisory machinery would be an essential part of the reorganised service, otherwise doctors' confidence in it will fall even further. The NHS and the profession must agree a practical system that is effective at regional, district, and unit level.

Many general managers will feel frustrated if they do not have managerial authority over clinicians. Indeed, it has been suggested that the present restructuring will be managerially ineffective without this authority. Did the Griffiths team and health ministers hold off from this logical completion of the management pattern because they feared that clinicians would not cooperate and thus the whole scheme would be jeopardised? Despite their calls for participation by clinicians the Griffiths proposals are clearly a major attack on professionalism, which many administrators think has impeded strong management of the NHS. Nevertheless, clinical medicine has its roots in doctor-patient relationships, and the purpose of NHS administration has been to support clinical medicine rather than to direct it.

This uncertainty about a key aspect of running the NHS suggests that the implications of appointing general managers was not sufficiently thought through. Thought through or not, these new managers will have a dramatic effect, for their arrival is probably the most radical change in NHS administration since 1948, downgrading the influence of the professions and concentrating power to make many executive decisions in one individual.

Ministers have made a virtue out of the sketchiness of the

new system by extolling the value of local flexibility, though this has not prevented them from taking a close interest in "local" matters such as the appointment of district managers. Unfortunately, the uncertainty engendered by the vagueness of the proposals was aggravated by the long delay in appointing the top manager—the general manager to head the newly constituted health board. This left the new structure leaderless at a critical time. This, the hectic pace, and the political pressures have not made it easy for health authorities to introduce the reforms. Inevitably, it will fall on them and their staff to try to make the system work. A major headache that they face, and one that will test the nerve and capabilities of every general manager, is how to bring clinicians into a management system that among other things seems destined—if not designed—to lessen the doctors' traditional power and influence. Though the Department of Health and Social Security has reached agreement with the clinicians' representatives at national level, translating this agreement into effective and harmonious management arrangements at district and unit level will be the real test of the new system.²

References

- 1 Burns T. The structure of organisations. In: Pugh DS, et al, eds. *Writers in organisations*. Harmondsworth, Middx: Penguin Books Ltd, 1976:17.
- 2 Department of Health and Social Security. *Health services management. Consultants and general practitioners in general management. Unit medical representatives with general management duties*. London: DHSS, 1985. (HC(85)9.)

(Accepted 3 April 1985)

Finance for Scottish health boards

Details have been announced of the financial allocations to the 15 health boards in Scotland for 1985-6. A total of £1353m has been allocated for gross recurrent expenditure commitments on hospitals and community health services and £36.5m for capital programmes. After expected income is taken into account the net cash limited allocations to individual health boards is as set out in the table.

Civil Service medical officers

In 1983 the council authorised the application to the Treasury for the BMA and the British Dental Association to be recognised as the negotiating bodies for medical and dental officers in the Civil Service. The Treasury indicated, however, that there was no justification for changing the existing arrangements under which the Institution of Professional Civil Servants was the recognised negotiating body. The civil service medical

officers group committee has decided that a further attempt should be made to achieve better representation and the council has approved the following proposals for re-establishing the joint BMA/Institution of Professional Civil Servants committee as a basis for further discussion:

"Terms of reference: To promote jointly the interests of doctors and dentists employed in the Civil Service, both in their professional field and in their terms and conditions of service.

"Constitution: Three representatives from each side, plus appropriate officers (on the BMA side, these will be the chairman and deputy chairman of the group committee and one additional member appointed by the committee in the light of the business to be considered.)

"Chairman and secretary: These would alternate at each meeting.

"Venue: Meetings would take place alternately at BMA House and the Institution of Professional Civil Servants headquarters.

"Meetings: As and when necessary, but at least twice a year."

BMA Thames regional office

The BMA's Thames regional office now has a separate telephone switchboard. Members in the Thames regions who have queries—on, for example, employment law, removal expenses, fees, contracts, health and safety—should ring 01 388 8296.

Financial allocations

Health board	Recurrent expenditure (net) (£m)	Ordinary capital programme (£m)	Total (£m)
Argyll and Clyde	97 737	2 970	100 707
Ayrshire and Arran	69 569	2 430	71 999
Borders	19 825	670	20 495
Dumfries and Galloway	35 034	970	36 004
Fife	65 372	2 210	67 582
Forth Valley	63 432	1 790	65 222
Grampian	119 417	3 330	122 747
Greater Glasgow	359 240	7 860	357 100
Highland	50 238	1 270	52 508
Lanarkshire	110 778	3 670	114 448
Lothian	216 977	5 710	222 687
Orkney	3 631	130	3 761
Shetland	4 542	160	4 702
Tayside	126 237	3 130	129 367
Western Isles	6 931	210	7 141
Total	1 348 960*	36 510	1 385 470

*Includes £12.8m allocated for specific commitments.