Managing without doctors: realities of Griffiths

NORMAN ELLIS

Medical influence on health service management at district level could be eroded as the new Griffiths management arrangements are introduced by district health authorities. Most districts are changing the composition and functions of the district management team to accommodate their new general managers.

District general managers are required to prepare new management arrangements for their districts, implementing the philosophy of the Griffiths report.[1] These proposals are submitted by district health authorities to the regional health authorities and the Department of Health and Social Security for approval. In many districts this task has been completed and the new management arrangements are being implemented. Most other districts have submitted plans to the regions and the DHSS and are awaiting approval.

The idea of a district management team was strongly supported by the much maligned "Grey Book," which laid down a blueprint for the 1974 health service reorganisation.[2] The district management team had two representative clinical members (a consultant and a general practitioner) appointed by their clinical peers, the district medical officer, district nursing officer, district finance officer, and the district administrator. Its task was to manage and coordinate the National Health Service's operational services. The district management team provided a structure that enabled consultants and general practitioners to participate directly in management.

The "Grey Book" favoured the district management team because it considered that the management arrangements required for the NHS were quite different from those commonly found in other large organisations. This was a strikingly different conclusion from that of the Griffiths report. The distinguishing characteristic of the NHS is that consultants and general practitioners have clinical autonomy so that they can be fully responsible for the treatment that they prescribe for their patients. These clinicians work as each others' equals and are their own managers. Hence the need to devise a management structure that would take account of clinical autonomy, one of its tasks being to reconcile the demands that are made on resources by clinicians in providing care.

The "Grey Book" proposed that clinicians should participate in mangement so that they could bring to it accurate and up to date knowledge of the clinical position and contribute to decisions on priorities. It would also enable clinicians to commit themselves to agreed proposals for change and obtain a full understanding of the impact of their own work on other parts of the health service. Hence the need for the district management team to operate on a consensus basis.

The health circular implementing the 1982 health service reorganisation gave each district wide discretion in determining its management arrangements.[3] It withdrew the prescription of particular district posts—for example, district personnel, works and supplies officers—and required the district health authority to appoint only a district management team. The district management team was required to formulate advice to the authority on district wide policies, priorities, and programmes, and to determine how district health authorities' decisions should be implemented. The team was to work on a consensus basis as a group of equals. The district administrator was responsible for accounting to the authority on how its policies and priorities were being implemented.

The position of the district management team was thus vindicated by the 1982 reorganisation. Indeed its future seemed secure, far more secure than the various district level posts, the existence of which was questioned by this health circular.

End of consensus management

While the 1982 reorganisation was still being implemented the government appointed an inquiry team chaired by Sir (then Mr) Roy Griffiths to examine and advise on management in the NHS. Its report advocated the introduction of general managers, and no time has been lost in implementing this recommendation.

The advent of the general manager has meant that the principle of consensus management on which the district management team was based has been cast aside. The Griffiths report was critical of consensus management because it led to "lowest common denominator decisions" and to long delays in the management process. It proposed the appointment of a general manager "to harness the best of the consensus management approach and to avoid the worst of the problems it can present." The general manager would be the final arbiter of decisions normally delegated to the consensus team, especially where these crossed professional boundaries or caused disagreements or delays.

Although the health circular implementing the Griffiths report refers to the continued existence of a management team, it does not prescribe its functions or composition.[4] It is for regions and districts to decide what new management arrangements should be introduced. This circular amends the previous guidance on managerial relationships in the 1982 reorganisation circular. The collective responsibility of the district management team has been transferred to the new general manager. How this manager delegates and shares his responsibility is a matter to be determined locally and a variety of arrangements are now being adopted by district health authorities.

The successor to the district management team has acquired many titles. A preview of more than a 100 district plans shows just how many permutations may be drawn from the terms—senior, general, corporate, management, advisory, policy, support, board, group, team—all of which are prefixed by "district." To avoid confusion in this article the new style team is referred to as the management board.

Because the composition of the new board is a matter to be determined locally, subject to approval by the region and the DHSS, this varies greatly between districts. The general manager is, of course, its chairman. Both the consultant and general practitioner representatives are included on the management board, though not always as full members. The position of the district medical officer is less clear and sometimes most unsatisfactory.

In most districts the district medical officer is included on the new management board, usually retaining his title and responsibilities. But some districts have either excluded the district medical officer altogether—at least one even abolished the post and made the district medical officer redundant—or have included the former district medical officer in the new board because he now fills some newly defined post—for example, as an assistant general manager or unit general manager. The latter approach has been widely adopted. Although the position of the present incumbent is protected, it raises doubts about the long term future of district medical officers. The job descriptions of these posts may be changed when they are vacated by this generation of former district medical officers and could be filled by non-medical staff. District nursing officers have

British Medical Association, BMA House, Tavistock Square, London WC1H 9JP

NORMAN ELLIS, MA, PHD, under secretary

usually been retained in posts with a bewildering variety of job titles—for example, patient care adviser, head of patient relations and quality assurance, director of standards, director of planning and service quality. The district treasurer is invariably included on the new board, though his job title has been changed in many districts.

Most districts are increasing the size of the board compared with the old style district management team. Some have included those district level posts whose existence was challenged by the 1982 reorganisation—for example, district personnel officers, district supplies officers, district works officers, and district dental officers —and again a variety of new and impressive sounding job titles have been devised for many of these posts. Indeed, the range of new job titles makes it difficult to compare like with like. This confusion is probably intentional in many districts; eagerness to be seen as "a new broom" seems to be a characteristic of many general managers and if a few "awkward individuals" in the previous management structure are swept out with it that is seen as a bonus.

Some districts have also included unit general managers (on average, three per district) in the new board. In others, however, a separate executive team apart from the management board is being formed that includes district officers and unit managers but excludes the consultant and general practitioner members. There may well be an important difference between these two approaches. Where this separation has been made already, the influence of the management board could wane as that of the executive team grows. The management board provides a forum in which both clinical and senior managers regularly review management policies and decisions, whereas a smaller executive team is concerned with the day to day management of the service. Even where a parallel executive team is not formally established it is possible that a cabal of general managers—drawn from both district and unit levels—will acquire increasing power, with the management board becoming little more than a sounding board for their decisions.

Clinicians unwelcome in management?

The Griffiths report attached a high priority to the participation of clinicians in management: "clinicians must participate fully in decisions about priorities in the use of resources." But it is quite clear that clinical participation at district level is being diluted by changes in the composition and functions of the district management team. Not only have many of these teams increased in size, inevitably reducing the contribution of clinicians, but their functions have become increasingly "advisory" rather than "executive." A case might be made for the profession withdrawing to an advisory role in management. Unfortunately, however, in many parts of the country the advisory machinery is not effective and would require a major overhaul if the profession decided that it would prefer to give advice rather than take part in management. In any case the profession would do well to review the methods for providing advice to the NHS.[5]

Barely 8% of the new district general managers are medically qualified; only three of whom have been drawn from clinical backgrounds. It is possible that the proportion of doctors appointed to unit general manager posts may not exceed 10% and some people believe that this is an optimistic estimate. Units are being enlarged as the number in each district is being reduced, on average, from five to three. This increase in the size of the unit has prevented the creation of those part time general manager posts which it was originally envisaged could be filled by practising clinicians. A few districts have even proposed withdrawing the payments made to consultants and general practitioners serving on district management teams on the grounds that the function of these teams has changed. There could hardly be a clearer sign that clinicians are unwelcome in management. In any case the profession has not helped itself or the NHS by the apparent reluctance of many doctors to take part in management. Though perhaps an understandable reaction to Griffiths, it can only strengthen the hands of those managers anxious to see the influence of the medical profession in the NHS reduced.

The exclusion of clinicians from health service management, whether intentional or not, is either reckless or naive, particularly in the present stringent financial climate. The brave new world of management plans and job titles may well falter and indeed founder if clinicians do not participate in the day to day management of the service. Has this first generation of district managers (most of whom are former administrators in a new guise) seized with relish a long awaited opportunity to run the health service without the assistance or interference (depending on where you sit) of doctors? Their heady and well executed initiatives may seem attractive to all concerned. Many clinicians may be relieved to have responsibilities of management removed, and many new general managers may welcome their greater freedom to run their services without the participation of clinicians.

This may prove to be a pyrrhic victory. To state the obvious, the essence of the health service is clinical care and doctors' daily decisions profoundly affect not just individual patients' lives but collectively the course of the NHS. Furthermore, clinicians will remain the main spenders of its resources. However impressive any district's new management arrangements may seem on paper, its success or failure will depend on whether it achieves its objectives. To attempt to do without the good will and close cooperation of doctors is foolhardy to say the least.

References

1 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
2 Department of Health and Social Security. *Management arrangements for the reorganised National Health Service*. London: HMSO, 1972.
3 Department of Health and Social Security. *Health services development. Structure and management*. London: DHSS, 1980. (HC(80)8.)
4 Department of Health and Social Security. *Health services management. Implementation of the NHS management inquiry*. London: DHSS, 1984. (HC(84)13.)
5 Ellis N. General practitioners and the Griffiths report. *Br Med J* 1985;**290**:483-5.

THIRTY YEARS AGO

Dr ROWLAND HILL, Chairman of the Central Consultants and Specialists Committee, presented a report on the "Medical Use of Hypnotism," prepared by a subcommittee appointed by the Psychological Medicine Group Committee. ... Professor T. FERGUSON RODGER, chairman of the Subcommittee, was invited to give an outline of the report. He said that as long ago as 1892 a statement had been put forward by a committee appointed by the Council of the Association to investigate the phenomena of hypnotism, its value as a therapeutic agent, and the propriety of using it. The subject had often been before the public, and, of course, it had been the happy hunting ground of the charlatan. The present report attempted a definition of hypnotism, touched on its importance to psychiatry and general medicine, and its place in medical education, stressed its dangers and the ethical aspects of its use, and set out the main fields which might particularly engage the attention of serious research workers.

On the motion of Dr. ROWLAND HILL the report was approved, and it was agreed that a lead should be taken in furthering research on the subject of hypnotism, and that the need for such research on the lines indicated in the report should be brought to the notice of universities and research foundations. Mr. LAWRENCE ABEL hoped that the research would not proceed on entirely academic or psychiatric lines, but that the general practitioner would be in some way integrated with it. (*British Medical Journal* 1955;i:197.)