Clinical freedom and management accountability*

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Administration or management?

Relations between clinicians and administrators in the National Health Service have always been awkward and in some senses unsatisfactory. Doctors have acknowledged the need for administrators in hospitals but have seen them as facilitators, whose role is to enable clinicians to get on with the business of seeing and treating patients. Success or failure has largely been judged by whether the patients' notes were in the outpatient clinic at the right time, the ward sisters had sufficient linen for patients' needs, and the hospital looked clean and cared for. The task of administration was to ensure that whatever policies were adopted were put into practice as smoothly, efficiently, and unobtrusively as possible.

Today's problems are different and demand different solutions. The overriding concerns of all hospitals are their cash limit and getting the best possible value for money. This must be seen against a background of enormously increased organisational complexity and an ever widening range of ways in which money can profitably be spent on the care of patients. The inquiry into the management of the NHS headed by Roy Griffiths was inevitable and desirable.¹ Management must be concerned with finding the best possible solution to the dilemma of matching finite resources to the rising cost of medical progress. It must identify new and imaginative ways in which things can be done, defining where the organisation is, where it wants to go, and how best to get there. The introduction of general management into the health service will be seen as a logical and beneficial step, but its impact will be crucially dependent on attracting the necessary talent. This year will be regarded as the watershed between administration and management in the health service, and few doctors can imagine the rigours that lie ahead. It seems unlikely that hospitals will escape the radical action faced by troubled commercial enterprises, and the immunity that hospitals have traditionally enjoyed from finance driven intervention will be a thing of the past.

Nature of clinical freedom

Clinical freedom—perhaps better described as clinical autonomy—has been the most dearly espoused principle in the practice of medicine in the United Kingdom. Its guaranteed continuation was central to the arguments that persuaded the profession to cooperate in the launch of the NHS in 1947. Every doctor has his or her own ideas of what it means, but the common theme is that doctors should be able to treat their patients as they feel best. All would defend it passionately were it threatened. Yet freedom in any civilised society is relative—for example, few doctors would suggest that their practice should be immune from the laws of the land, and most accept without comment that their professional activity is to some extent circumscribed by the General Medical Council, by professional ethics, and by social convention. These are not issues at present, but what is of great importance is the extent to which clinical autonomy is being eroded by lack of money for the NHS. Money has always been short but the present shortage is endangering both the standards of clinical practice and the volume of clinical service.

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Clinical autonomy is a feature of practice to which doctors alone have successfully laid claim. But other health care professionals are now casting envious eyes on it. The essence of clinical autonomy is that the contact between patient and doctor is not in any way influenced by managerial decisions—"managerial" in the Griffiths sense. Since 1948 this feature of medicine has derived from a concept of social policy on which the NHS was consciously founded—namely, a one to one relationship between a named patient and a named doctor. This is an expensive way of providing care but is the only basis on which confidence can be built at a time of vulnerability and need. Furthermore, it is the only civilised and ultimately efficient way of providing care of high quality.

Professor Elliott Jacques's group at Brunel University has argued that there are at least four components of clinical autonomy.²

(1) Independent practice: the relationship between the patient and doctors is not subject to scrutiny by others.

(2) The right to choose: this is enshrined in legislation and enjoyed by both patient and doctor.

(3) Prime responsibility: doctors alone among health care professionals determine which of the resources of the service should be mobilised and brought to bear on a particular patient.

(4) Primacy: a recognition that the doctor usually has a wider and more comprehensive knowledge of the problems and ways in which they may be solved than other health care professionals.

These principles may be questioned—notably whether or not the patient really does have the right to choose which doctor he sees. This does, however, remain a feature of general practice where a patient signs on with a doctor of his choice and in hospital where a consultant is responsible for the actions of his junior staff. Other health care professionals can certainly claim that their practice is characterised by some of these features, but only doctors can reasonably assert that all four apply to their work. Even so, whether other groups of health care professionals should be granted clinical autonomy will soon become an issue.

There are certain consequences of accepting this analysis of clinical autonomy: firstly, it profoundly influences the ways in which hospital doctors are organised in a self regulating peer group and not in a hierarchy. This imposes great organisational complexity on institutions in that the most powerful group of individuals is outside the normal management and work force relationship. Secondly, any departure from the principles on which clinical autonomy rests could result in a threat to that independence. (Were that argument to be accepted it would, for example, raise questions on the use of general practice deputising services, which are managed services in which the patient has no influence over which doctor he or she may see.) Lastly—perhaps another way of making the same point—clinical autonomy imposes an obligation on the profession to keep its side of the bargain and to honour these principles.

Money and opportunity costs

Ask the man in the street what the main problem of the NHS is today and he would probably answer "lack of money." How much money should be spent on health care is a question to which there is no certain answer, for it depends on political, economic, and social as well as medical judgments. Doctors will rightly fight for as much money for the NHS as they can possibly get, but advances in medicine mean that there will be an ever widening gap between the amount of money any society can provide for medicine and the ways in which doctors can spend it. The NHS will never be able to pay for everything that doctors would like to do for their patients. While it is easy to argue that the remedy is more money in a government financed service there are only two ways of getting this: by

increasing the proportion of the gross domestic product spent on health care, or by increasing the nation's wealth. Even if either of these were a realistic prospect medicine would still be entering an era of choices.

Of help in making choices is the concept of opportunity cost in which a particular service or item of equipment is examined not in terms of pounds and pence but in terms of what must be foregone to purchase the commodity in question, and this is particularly relevant in the context of cash limits. The cost, for example, of a drug dependency unit might be the inability to open a day care unit for terminations of pregnancy, or vice versa.

Making the best use of what we have

If the argument that the NHS can never again fund everything that medicine would like to do is accepted it removes some of the emotion and doctors' central concern becomes how to make the best possible use of what is available, which leads to the need for imaginative management. It is inconceivable that this should not involve clinicians, and for doctors to distance themselves from that process would be to act against the interests of their patients. The whole managerial process must be informed by and be sensitive to all aspects of patients' needs and of those who look after them. If this is skilfully done accountability for the management of resources consumed in the care of patients will be seen as ultimately the only way in which the best use of what money there is may be assured.

Inefficient and wasteful clinical policies will be seen as having unnecessarily high opportunity costs, and properly conceived budgets that are overspent may be interpreted as an attempt by one service to hijack the money set aside for another. Such practices cannot be tolerated by the management of any institution dedicated to the most efficient and effective use of its funds. Sooner or later the management would be (and has been) driven to take steps that result in changes of practice on the one hand, or whatever steps are necessary to live within the budget on the other. Such action inevitably threatens or infringes clinical autonomy. So it is clear that accountability to management decisions—in which clinicians should have every opportunity of taking part—is a necessary prerequisite of clinical autonomy. Several examples already show that overspending on clinical services, however desirable, will not be tolerated, resulting in management action to reduce clinical resources and thus removing the freedom of doctors to see patients who would otherwise have been treated.

Where does a clinician's responsibility lie?

Discussions about adequate clinical resources always raise the question of the clinician's responsibility to his patients. Almost all doctors will hold that their first responsibility is to their patients. Those who also recognise some responsibility to management—and they probably now represent a narrow majority—are placed in a genuine dilemma. A few clinicians avoid the issue by arguing that they should have nothing to do with management at all and that cooperation can only compromise them. This may be understandable but is a form of purism that must ultimately damage the interests of the patients. While every doctor recognises his duty to the patient sitting in front of him few doctors would argue that they have the same responsibilities to patients whom they have not yet met but who might benefit from their advice.

Health authorities, too, are charged with providing a range of services for local residents; they have the right and duty to determine the mix and the pattern of the services which they will provide with their cash limited resources. So it is proper that they should determine, with appropriate advice and participation by clinicians and other interested parties, how much money should be spent on acute services and how much on services for the mentally ill, the mentally handicapped, and other groups. When a clinical service overspends its budget it can do so only by denying services to another, perhaps less vocal, group of patients for whom the authority has an equal responsibility. Herein lies the key to

resolving the conflict facing doctors. The fairest way to resolve or to avoid such conflicts is to determine prospectively the volume of care that can be provided for each group, preferably by setting budgets, a system that has the advantage of encouraging ingenuity, flexibility, and economy.

Conclusion

The present relative shortage of money in the health service is bound to lead to stresses and strains. The influence of clinicians in the hospital service has been stable and powerful since 1947 but their "organisational" relationship with the administration or management has ranged from fragile to difficult. The inexorable pressure on finance resulting from national redistribution policies, cash limits, regional redistribution mechanisms, demographic change, advances in treatment and technology, and much tighter control of public spending have made more active and interventional management imperative. On several occasions recently this has led to management curtailing clinical services and this has raised the legitimate fear that clinical autonomy is under siege. There are likely to be many more such incidents in the future.

Clinical autonomy is alive and well in the NHS, but it must adapt to changing circumstances if it is to continue to benefit patients and the profession. The principle is as keenly supported by NHS managers as it is by doctors because it is recognised as the cornerstone of a high quality service. Our present difficulties arise from the extent to which financial considerations obtrude into clinical practice. The Secretary of State, through the health authorities, has a statutory duty to provide a range of medical services, but there has never been any obligation to provide a wider range or greater volume of them than society is prepared to pay for. In such changed circumstances clinical autonomy can be preserved only if those who commit the resources accept accountability for their proper usage. In the interests of the patients they must also share in making the decisions on how they should be distributed.

References

- 1 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 2 Jacques E, ed. *Health services*. London: Heinemann, 1978:44.

THIRTY YEARS AGO

To reduce anxiety and to help parents to understand hospital regulations, the Central Middlesex Hospital gives a printed pamphlet, signed by the children's physician, to parents of children admitted as in-patients.

The pamphlet describes in simple terms the emotions of a child left in hospital and prescribes some rules for parental behaviour. "You can visit your child every day (except Monday and Thursday)," the pamphlet states, "and either you or your husband, or both of you, should try and come if possible, in order to increase his happiness and sense of security while in hospital, and to reduce his emotional disturbances after returning home. This privilege is for parents only and your friends will not be allowed into the ward. . . Please don't promise to take him home every time you see him. He will soon learn that this is not true and he will lose confidence in you. Instead, tell him that he can come home as soon as he is better, and that this is for the doctor to decide. There may be times when sister will advise visiting more frequently or less frequently. Please accept her advice without argument."

Some good advice is given about "tit-bits": "Please do not feed your child when you come. . . Any gifts of food or sweets which you may bring should be handed to the sister, who, to avoid any feeling of unfairness, will pool these and share them equally among all the children after their meals. Under no circumstances should you give anything to any other child in the ward."

The risk of infections in the ward is explained, and the pamphlet concludes: "Please don't listen to what your friends, neighbours, relatives, or other parents have to say about your child's illness. . . If you want to know how he is getting on, ask sister, and, if necessary, she can arrange for you to see the doctor." (*British Medical Journal* 1955;ii:17.)