Management training for clinicians

HELENA WATERS

Previous reorganisations of the National Health Service have barely affected the practice and behaviour of doctors. The Griffiths management reforms will, however, draw them much more into the management framework. This management reform is not just about a few doctors becoming general managers, but about all doctors becoming managerially accountable for the quality of their service and the resources that they commit.

Historically, the NHS has encompassed two parallel "cultures"—the professional and the administrative, with doctors operating from the professional side and committing most of the service's resources. As professionals they see their function as providing the best possible service to individual patients—they are interested in the quality of results—and they set the standards. The "administration" sets up the structure and systems to get things done by laying down rules, regulations, and orders aimed primarily at obtaining and deploying as efficiently as possible the resources committed by professionals.

When resources were more adequate—or more so than is now the case—the professionals were able to operate according to their value system without conflict with the "administration," which in turn maintained the NHS in a steady state. Now, however, the two groups are in conflict because of the need to "manage" resources. Thus while for most of its existence the NHS has been "administered" rather than "managed" the Griffiths inquiry recognised the need for management. "Management" will care about and understand the values of both the professional and administrative sides—it will speak both languages, and get them to work together to provide a service of good quality within the constraints of resources provided by the government.

Difference between management and administration

Doctors often confuse management and administration. "Management" is a proactive process requiring decisions about where an organisation is going, strategies for achieving stated goals, implementation of the strategies, and evaluation of the outcome. "Administration" is keeping the ship on a course determined by someone else.

Many doctors will no doubt protest that they already undertake management. But there are several key differences between what doctors have done in the past and what will be expected of them in the future. Few doctors, for example, have had responsibility for managing a budget or have had line management responsibility for non-medical staff. The exceptions have been heads of service departments, such as pathology and radiology, where these management tasks are seen as an integral part of the job. As a result management education is emphasised in the training for these posts—a lead that perhaps the rest of the profession could follow. While community physicians are trained in the wider social, political, and economic implications of delivery of health care to a whole population their training has rarely included training in management skills.

Integration of management education and clinical skills training

There is now an urgent need to incorporate management education as early as possible into the medical curriculum to ensure that medical graduates have a realistic appreciation of the management component of their future work and positive attitudes towards it. At postgraduate level this educative approach could be developed to include the acquisition of management skills alongside training in clinical skills, so that the two elements are seen to be complementary, rather than in conflict, which is how they are presently perceived by many. If such a management development approach is used all doctors will be encouraged to have achieved adequate management knowledge and skills appropriate to their level of clinical functioning—for example, as junior doctor or senior registrar (up to which point there is minimal management responsibility) or as newly appointed consultants (when doctors first become managers) right up to the level of the more experienced consultant who may wish to opt for a career primarily as a manager.

Revision of the profession's career structure is overdue, and progression into general management (in much the same way as chemists or scientists in industry progress to become managers) should be recognised as an acceptable career for doctors, with the relevant training made available for those who wish to enter NHS management.

The appropriate coordinating centre for most of this postgraduate and continuing management training and education could be the regional health authority, with someone, preferably a doctor, being made responsible for establishing and running the management development programmes for doctors.

Some regional training departments have started to implement such programmes. Budgets for management training for doctors in most regions are small or non-existent, so choices have been made about where to invest resources. One or two regions are specifically aiming their courses at senior registrars, others at newly appointed consultants. At least one authority is planning to institute gradually a management development programme that starts when a doctor is appointed as a senior registrar and provides relevant training throughout the rest of his or her career. A regional management development adviser for doctors could also recommend other relevant nationally organised management courses as appropriate—for example, those organised by business schools, national training centres, or professional groups.

New approaches to management training for doctors

Much of the traditional management training for doctors should be reviewed because the content of most programmes has been mainly concerned with steady state management or the "administrative" function. Good general managers in the NHS, whether or not they are doctors, will in addition need to practise a different sort of management—that is, the ability to manage change by paying attention to the environment (social, economic, political, and technological) and continually questioning the conventional wisdom of the day.

Management development programmes that create an environment in which doctors feel "safe" enough to question what they and their colleagues are doing can effectively expose many managerial issues, more so than is possible in conventional management courses, which consist largely of lectures and didactic teaching. In a course lasting several days, at the most the objective should not necessarily be to equip participants with new skills but to increase their awareness of the qualities required for management. Indeed,

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most learning and the acquisition of management skills should take place in the workplace rather than on courses.

Training should be relevant to what the doctor sees as his primary task—delivering good quality health care. Courses should therefore deal with issues that are pertinent to every day practice, using methods that allow course participants to try out a new skill or technique with review or reflection time built in—that is, learning through doing. Doctors are themselves surprised at how appropriate experiential “games” can highlight the processes that accompany any task. Role play exercises can reflect realistically the problems faced by members at a meeting of a division in a hospital or of relationships between management and workers in an organisation. The use of case studies to highlight concepts such as resource allocation and budgeting is now quite common, as are video feedback of sessions focusing on interpersonal skills. Other audio-visual and computer based methods are also used.

One of the newer learning environments being experimentally used in the NHS is in the form of an outdoor management course, where small multidisciplinary teams are set a series of tasks and problem solving exercises using a setting in, say, a forest. The need for teamwork, good communication and leadership skills, and opportunities for creativity and innovation are emphasised. Such a training exercise is not completed without an equivalent amount of time being spent back in the “classroom” trying to understand how the tasks were achieved. Participants report that the reality of the setting produces more effective learning than other methods. With more emphasis on multidisciplinary working and with doctors having to accept executive management from other professions, this might become a useful training technique in the future.

On the job “action learning” approaches are being developed in some regions, which use management consultants and members of the training department to work with staff who have a problem related to changes in service delivery—for example, moving services to the community. Much multidisciplinary training is carried out as part of managing the change, and doctors are actively concerned at this level. Additional training needs for individuals may be identified and provided for in subsequent training courses.

Content of training

In a short article it is impossible to do justice to all the subjects that might be covered in a management development programme for doctors. The table includes some of the areas that might be covered.

Elements of all three sections can be incorporated at any level in a management development programme, so long as the content is made relevant to everyday work issues. Medical students and established consultants alike find exercises in communication and decision making skills relevant, whereas case studies relating to

Some management topics to be covered in training

Understanding of:

- The NHS as a human service organisation—models of organisations, managing change in organisations.
- The changing environment of the NHS—political, social, and economic.
- The role of the doctor and others in the NHS.
- General management—what it is and is not, how it will affect doctors, management accountability.
- Management jargon.
- Population versus individual patient needs—an epidemiological perspective.

Specific management techniques:

- Financial management, management budgeting.
- Value for money, opportunity cost.
- Measuring outcome, effectiveness, quality.
- Information collection and handling, use of computers.
- Option appraisal, making a case.

Management skills:

- Negotiating and influencing skills.
- Man management, working with people.
- Leadership, multidisciplinary teamwork.
- Time management.
- Communication skills.
- Decision making skills.
- Committee and chairing skills.

management budgeting will be of more use to consultants who wish to know more about that particular management technique.

Training for medical general managers

Some doctors will already have decided to become general managers or will wish to know more about it and how to do it. Short term “bridging” training for doctors who are shortly to become general managers is urgently required. The new NHS Training Authority has authorised a series of training programmes specifically for unit general managers to be held at various business schools and training centres nationally. In keeping with the spirit of general management and the need to reduce “tribalism” in the NHS doctors will be encouraged to attend multidisciplinary courses.

In addition to these initial modules, which will of necessity be short, most general managers will need continuing support and training, some of which might be arranged formally at regional or national level. Much support, however, will come from the informal networks and contacts that tend to evolve from formal courses or working arrangements. The sharing of information between those with similar problems and the mutual support that such networks provide will be essential for newly appointed general managers.

A more strategic approach to training will require us to select from management development programmes those doctors who are interested in or show potential for management so that their training can be individually tailored to enable them to take general manager posts in the future. In any case, doctors training for careers as consultants should be brought up in a management “culture” so that it will not be necessary to “teach old dogs new tricks.”

THIRTY YEARS AGO

Burdens of the Doctor's Wife

SIR,—May I, as a doctor's wife with some 15 years' experience of coping with the permanent coverage required to help a G.P. execute his duties (and by coverage I mean wife, housekeeper, maid, secretary, receptionist, sitter-in, family, daily help, and professional phone-answering service), ask why some reasonable measure of relief from the tedium of this constant and permanent responsibility cannot be arranged? Even if the doctor buys himself some free time by providing a deputy, this coverage must still continue 24 hours a day, and it is usually the doctor's wife who has to arrange for it. This means that at a time when battles are being fought for a 40-hour working week, cover must be provided for the doctor for 168 hours a week, every week of the year including all holidays. I also begin to wonder where large and busy medical households are going to find their staff in the future, what with the competition to be found in advertisements in the daily press such as the following: “Help req., single lady, mod. flat, help given, out all day, away most week-ends,” etc.

My object in writing this letter is not to suggest that the doctor evade his duty or obligation to his patients, but surely some better working arrangement can be organized than this. Would it not be possible, for instance, for evenings from 8 p.m. to 8 a.m., and at least part of Sunday, to be organized by an emergency service which the doctors could man themselves? Would it be so very terrible for a doctor to put in a mere 80-hour week and for him not to be obliged to answer his phone and door during the emergency period? The public could be given some simple number like “dial ‘D’ for doctor,” which when used would immediately put them in touch with the emergency service in their area wherever they might be. Treatment given by the emergency doctor could be passed on to the patient's own doctor the following morning in very much the same way that rotas are being managed now (except, of course, that nobody would be needed to cover the rota). A doctor might perhaps be allotted one night of emergency duty in a month, which would allow him and his family to live like normal human beings at least for the other evenings.

I am sure that if some way could be devised to ease this burden, holidays and leisure time, which are at present only arranged with considerable difficulty, could be managed more easily. At the moment I think the only G.P.'s wife who appears to be free from these problems is Mrs. Dale. I would be interested to hear whether other doctors' wives feel as I do about this—but no phone calls, please!—I am, etc.,

BRYNA LEWIS.

London, W. 9.

(*British Medical Journal* 1955;iii:163.)

"The ethical imperative of clinical budgeting"

"The NHS could achieve better patient care outputs in quality and quantity for the same level of expenditure," say Iden Wickings and James Coles in their Nuffield/York portfolio publication, and "that in essence is the ethical case for clinical budgeting." In *The ethical imperative of clinical budgeting* the authors point out that clinicians are already making difficult ethical decisions on the allocation of rationed resources not only between patients but between whole health care areas—such as the provision of care for the chronically ill, acute high technology medicine, and preventive medicine. These decisions, however, are not made on the basis of estimates of the benefits to be sought, and little quantitative analysis takes place. Wickings and Coles say that "some form of choice has to be made between the competing options under all systems of health care." As clinicians are the only experts who can weigh up the clinical merits of different forms of treatment and predict the need for therapies in the future, as well as predict the implications of new work on demands for treatment, they must take part in allocating appropriately these restricted resources. The authors look at one of the clinical budgeting experiments—that of the planning agreements with clinical teams group—and conclude that this form of cooperation between managers and clinicians, where each is aware of the constraints that the other has to work within, is the only way to achieve patient sensitive budgetary control. The BMA's *Handbook of Medical Ethics* states, "as the resources available within the NHS are limited the doctor has a duty to advise on their equitable allocation and efficient utilisation. This duty is subordinate to his professional duty to the individual who seeks his clinical advice." The paper makes the ethical case for clinical advice being taken when allocating resources, but the "experiments in clinical budgeting" to which it refers have not yet persuaded the profession as a whole that this is the most desirable way to give that advice. Nuffield/York portfolios are available from the Nuffield Provincial Hospitals Trust, 3 Prince Albert Road, London NW1 7SP, price £1.25.

Limited list—first results of advisory committee deliberations

The new Minister for Health announced on 24 October—in answer to a parliamentary question—that oral mucolytics would continue not to be generally available under the NHS. The advisory committee on NHS drugs had completed a review of this group of drugs and concluded that there was no satisfactory evidence of their therapeutic value in the treatment of respiratory disease or "glue ear." The committee did, however, recommend that drugs from this group should be available under the NHS for certain very limited conditions. The minister will therefore be introducing further amending regulations to make carbocysteine available for the management of children with tracheostomies and—subject to a decision of the licensing

authority—acetylcysteine for patients with cystic fibrosis associated with abdominal conditions. The draft regulations will be presented to the General Medical Services Committee for consideration in due course.

1986 Junior Members Forum

The topic for the symposium on the first day of the 1986 Junior Members Forum on 5 and 6 April will be "Medicine, ethics, and the law." The forum will be chaired by Dr G Parker, and the speakers will be:

Lord Rea, general practitioner.
Sir Zelman Cowen, provost of Oriel College, Oxford.

Professor G R Dunstan, emeritus professor of moral and social theology, London University.

Professor Ian Craft, director of gynaecology at the Cromwell Hospital, London.

The BMA has applied for approval of the symposium under section 63.

The second day (6 April) will be devoted to medicopolitics. One of the BMA's senior elected

The Charlotte Mason College, Ambleside.

officers will address the meeting, and there will be reports from the forum's representatives on the council and the representative body. Motions on any subject arising from the reports or related to the practice of medicine that have been tabled during or before the meeting will be debated and voted on. Resolutions from the forum are referred to the council, standing committees, and the representative body.

The forum, which is open to members of the BMA who are under 40 and within 12 years of provisional registration, offers an opportunity to exchange ideas and to gain an insight into the affairs of other sections of the profession.

The 1986 forum will be held in the Charlotte Mason College of Education, Ambleside, Cumbria, where overnight accommodation will be available on Friday and Saturday, 4 and 5 April. The meet-

ing will last from 10 am on the Saturday morning until 3.30 pm on Sunday 6 April.

On the Saturday evening there will be a special dinner with the Lancaster division of the BMA.

Further details about the forum, including the procedure for electing representatives, are available from BMA regional offices.

Occupational health

The occupational health committee of the BMA met on 25 September, when Dr W M Dixon was re-elected chairman and Dr H G Vaile deputy chairman. The committee discussed the slow progress of the establishment of an occupational health service for the NHS, and it is continuing to monitor the position. The committee is also studying proposals from the Health and Safety Executive for the introduction of revised reporting arrangements of occupational ill health. The White Paper *Lifting the Burden* was discussed and committee members were concerned at the proposal that the lower limit of liability under the Health and Safety at Work Act should be raised from five to 20 people. This, the committee believed, would remove protection from the most vulnerable members of the working population. The meeting welcomed proposals to simplify the present statutory sick pay rules.

Dirty kitchens and Crown immunity

Did the government intend "to remove the current restriction, which inhibits environmental health officers from investigating the cleanliness of hospital kitchens?" In reply to this question in the House of Lords Baroness Trumpington, for the government, replied that these officers should have open access to hospitals and that the government was looking into ways to strengthen existing guidance, and into the possibility of lifting Crown immunity.

In response Lord Boyd-Carpenter, who had asked the original question, pointed out that environmental health officers had no power to impose higher standards either by prosecution for breach of law or by threat of prosecution. "Does it not strike the noble Baroness as a trifle odd," his Lordship continued, "that the environmental health officer for Westminster, for example, can hunt cockroaches in the kitchens of London clubs but is forbidden and unable to prosecute hospitals which have dirty kitchens which endanger the lives and health of their patients?"

Lord Ennals, a former secretary of state for social services, supported him, claiming that it was quite illogical for hospital kitchens to be protected by Crown immunity. Pointing out that Crown immunity applied to prisons and a great many other places, Baroness Trumpington concluded by saying that if such immunity was to be lifted and a dirty kitchen unfortunately found the kitchen would have to be closed immediately. "One has to take that factor into account in considering the lifting of Crown immunity in institutions such as hospitals. As I have said our main objective is prevention not cure."

A delegation of members of parliament, environmental health officers, local councillors, nurses, and trade unionists met the Minister for Health, Mr Barney Hayhoe, on 28 October to urge him to support a private member's Bill to abolish Crown immunity proposed by Mr Jack Ashley.