TALKING POINT

Management tensions in laboratories

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The pathology laboratory services in the National Health Service are undergoing profound changes, which are already affecting the workload of many pathologists and could affect them all. Though many of these changes are presenting in other disciplines, some are unique to pathology and are due to the size, cost, and complexity of the work of individual departments.

Judging by the number writing to their professional organisations, many pathologists are uneasy about the changes. Yet there is no simple explanation of the cause of the unease as the changes in the NHS differ substantially in type and pace. This variation makes any national analysis difficult, not least because pathologists drawing on their local experience will disagree. Even within one laboratory the experiences of the individual specialties may differ.

Though easier said than done, it is important to try to analyse the changes within a national framework if we are to get some feel for their potential effect on the future direction and quality of the service. The issues considered are not in priority order.

Management structures

Two of the more important changes affecting pathology laboratories can be attributed to the Griffiths report and its subsequent implementation circular.^{1,2} These recommended the introduction of general managers and management budgets for clinicians. As health authorities were given discretion about the extent and timing of the changes it is only in the past two years that the details have begun to emerge. The discretion allowed in HC (84) 13 has led to a diversity of practice between districts.

There are different staffing structures in laboratories, one for doctors, one for medical laboratory scientific officers (MLSOs), and one for professional and technical (A) scientists. In nearly all laboratories pathologists may be in one of several specialty departments—for example, chemical pathology, haematology, etc. Within the departments consultants are clinically autonomous and direct the work of junior doctors. Under the terms of a 1974 circular one of the consultants is identified as head of department, “responsible for the proper functioning of the department.”³ The same section of the circular indicates that the head of department has management duties but that he or she also has responsibility to delegate appropriate management functions. The only variation in this arrangement is the recognition that the head of department could also be “a non-medical scientist of equivalent standing” to a consultant—that is, the biochemists and microbiologists, etc, employed on the Whitley Council Professional and Technical (A) scientific grades.

Most laboratories have a higher tier in the medical structure at laboratory level based on the cogwheel division. In most cases one of the departmental heads will act as chairman of the division for a period of years rather than indefinitely and will represent his colleagues at district level on the cogwheel executive. Before the introduction of general management this role was largely representative and advisory and many divisions operated without any overall managerial authority being vested in the chairman. But the concept of personal accountability has led district general

managers to seek to vest the chairman with a managerial authority over his colleagues and particularly over the heads of department in the conduct of their management functions, while recognising that this should not infringe their medical colleagues’ clinical autonomy. So far some district general managers have ignored the issue of personalised accountability or have delegated the responsibility to unit general managers who have in turn ignored the issue or chosen to leave it alone. Others—the majority—have reacted with a heavier or a lighter touch according to personal style or temperament. Some laboratories now have a cogwheel chairman who is either director or manager of the pathology laboratory service, while others retain a chairman with assumed managerial control. In many divisions it is not clear whether the chairman has a personal and individual managerial accountability upwards or whether the division itself and its members have a collective managerial accountability; this has been left deliberately vague in some structures. What seems clear, however, is that taken together these variations have created some uncertainty and some tension in the relation between department and laboratory within the medical structure and that among pathologists each management model has its advocates and its detractors.

The second staffing structure in the laboratory is that of the MLSOs. Existing Whitley Council regulations prescribe a hierarchy of posts in departments from senior chief MLSO down to basic grade, with the senior chief having a supervisory role over the work of other MLSOs in the department. At the laboratory level there is provision for a higher graded post beyond the individual departments (often called a floating post) graded as principal if there are 63 or more MLSOs employed or as senior chief if the laboratory has fewer than 63. Where an MLSO is appointed in this floating role the Whitley Council agreements require that he or she has “overall technical charge of a laboratory.”⁴ The definition of this phrase is less than clear; it does not refer to managerial control because the request for that title has so far been refused by the management side of the Whitley Council, yet it must imply some technical control over the work of departments.

It is the relationship between the medical and MLSO structures that causes so many of the difficulties that have dogged pathology laboratory management in the past decade. The structures owe their origin to different sources and it is ultimately the health authority’s responsibility to fit them together in a way that produces an efficient and reliable pathology laboratory service. The past two years have seen a growing number of variations in the relationship between the two structures.

VARIATIONS BETWEEN STRUCTURES

Some districts have chosen to interpret the phrase “overall technical charge” as meaning management accountability and have made all MLSOs across all departments managerially accountable through the senior chief MLSOs to the principal. Where this has happened the title of head of department may have been left with the pathologist, but the status of the title has been eroded because the head of department is limited to working by consent through his senior chief MLSO and where that does not work is required to appeal directly or indirectly to the principal. In those circumstances the head of department may not be able to carry out effectively the managerial duties assigned under the circular HSC (IS) 16. In some cases the title head of department has become purely honorary.

Variations have been introduced into the management accountability of the principal MLSO. In most cases the chairman of division will be either a

medical consultant or a top grade scientist of equivalent standing. Some pathologists justify the erosion of the managerial position of departmental heads by explaining that the principal MLSO is still managerially accountable to the chairman of division and hence can still be instructed in the event of any breakdown of normal working relationships in the laboratory. Some districts, however, have attempted to divide managerial and clinical responsibility, making a principal managerially accountable to a unit general manager while clinically accountable to the chairman of division. Alternatives have been to make the principal accountable to the unit general manager and responsible to the chairman of division or vice versa. This development is commented on later. At best the precise relation between the chairman and the principal is left vague and uncertain, and at worst, from the point of view of the consultant, managerial authority is withdrawn at both departmental and laboratory level. Finally, these problems are exacerbated by the different appointment conditions of the chairman of division and the principal. The chairman of division holds the post for a limited number of years on rotation while the principal remains in post for life. Under these circumstances the principal increasingly becomes the focus of continuity in the laboratory, the repository of knowledge about the laboratory and its management, and ultimately the contact chosen by senior NHS staff outside the laboratory when wishing to ask questions or to communicate. Thus the position of the principal is enhanced relative to the chairman of division, and it is not untypical for long established principals to have wide authority and newly established principals to have less.

In face of these variations the Royal College of Pathologists has made its own recommendations to consultants. The college has argued strongly against any fudging of relations between the medical and MLSO structures. "For the proper functioning of a department there must be efficient management and clear delineation of roles and accountability within the department."⁵ It gives full support to the circular HSC (IS) 16 in identifying the department not the laboratory as the appropriate level for management accountability and its most challenging recommendations are in paragraph 6, where it identifies the duties of "the most senior MLSO" as belonging to the most senior MLSO *within the department*. The college says that if some duties still have to be performed on a laboratory wide basis these should be undertaken by the most senior MLSO within a department, who merely has an extension of his duties and a grading to recognise the extra work.⁵

This direct challenge to established practice in the laboratories has been taken up in several districts and some principal posts are either being abolished or existing principals are having their duties changed with the approval of district general managers to fit with the recommendations of the royal college.

MOVING ON TO THE WARDS

Consultant pathologists are also responsible for the final type of variation emerging at present. Many haematology departments have only one or two consultants and a growing number of haematologists seem to have identified their future as being in the wards treating their own patients. These consultants have tended to move out of the laboratory, delegating substantial authority to their senior chief MLSO for the day to day running of the department. Where there are two haematologists, one of whom remains in the laboratory and one who works outside, this outcome is avoided, but where only one haematologist is employed and he or she chooses or has the opportunity to work outside the laboratory there are clear examples of de facto managerial control passing to the senior chief MLSO. This phenomenon may also weaken the training programme for junior medical staff and of medical students.

As yet only a minority of laboratories are affected but the result could be serious. Senior chief MLSOs in other laboratory departments can and have become resentful that the scope and authority vested in their colleague in haematology is not vested in themselves in, for example, histopathology or microbiology. In as much as this development causes discontent it makes it harder to achieve the close working relationship between professions that is so strongly recommended in the report from the Royal College of Pathologists.

The non-medical scientists covered by the Professional and Technical (A) Whitley Council—for example, biochemists and microbiologists—constitute a third staff group in the laboratory and one with an important contribution to make in literally every department of the laboratory with the advent of non-medical scientists in haematology. These scientists have a structure based entirely at departmental level. From top grade with greater responsibility to basic grade, the biochemists, microbiologists, and cytogeneticists, etc, work entirely in departments and do not have managerial or clinical structures beyond the department. Their existing Whitley Council structure is therefore entirely consistent with the management framework outlined in HSC (IS) 16 including their potential role as head of department and beyond that as chairman of a cogwheel division.

Anyone who has analysed these developments cannot help concluding

that laboratory staff have not been well served by the NHS in attempting to provide, maintain, and manage an effective clinical service. From one part of the Department of Health and Social Security has emerged a precise circular that clearly delineates responsibilities but is advisory only and has no statutory authority.³ Another part of the DHSS has negotiated a vague Whitley Council agreement couched in ill defined language, capable of meaning all things to all people, which has full statutory authority. Arguably, these documents have never been consistent. They derived from different parts of the department, and although they bear the Secretary of State's authority they leave districts with the responsibility of interpreting their meaning and implementing them.

Against this background the local responsibility has often been avoided with district general managers and unit general managers fighting shy of hard decisions and perpetuating vague and uncertain relationships that can so often lead to animosity. The most cynical example comes from those districts that have instituted a division between the principal MLSO's accountability to the chairman of division and his responsibility to the unit general manager or vice versa. In this context the division between accountable and responsible is immaterial. The general manager's action is merely an escape from having to make a decision, but one made at the cost of continuing uncertainty and confusion in the laboratory concerned. A further example of district ineptitude can be drawn from the small minority of districts that have formally given their principal MLSO the title of laboratory manager because of pressure from the trade unions without at the same time clarifying what or whom he or she manages.

Another example of the department's failure to serve consultants well was the chief medical officer's letter of January 1986 to a consultant radiologist in which he confirmed that the advice given in HSC (IS) 16 had not been superseded and that a department should be headed by a consultant or non-medical scientist of equivalent standing. But despite the well known confusion over this particular circular no explanation or advice was given to districts to ensure that they fully understood that the implementation of the Griffiths report had in no way affected the status of HSC (IS) 16. The result is that despite the chief medical officer's clarification to the medical profession, which is wholly acceptable to doctors, district general managers can still rightly claim that they know nothing of this.

Clinical budgeting and resource management

The second initiative of Griffiths was the recommendation to introduce management budgets for clinicians. There have been demonstration districts, second generation districts, and now six new districts for piloting resource management.⁶ Resource management affects all specialties in the districts and units in which it is introduced. Beyond this, however, many districts have attempted to develop different systems of resource management and management budgeting, usually with the aid of external management consultants. Some of these have included attempts to cost individual tests and requests in pathology as a forerunner to a wider district scheme or perhaps only as a means of identifying and controlling the major areas of expense.

Such experiments lead inevitably to the development of performance indicators and the comparison of performance between laboratories within a region and nationally. The Royal College of Pathologists is clear that the head of department should be responsible for "personnel, finance, accommodation and equipment" and "ensure that resources are used effectively. The principal criteria governing budget expenditure are the clinical demands made on the department. Clinical priorities may change rapidly and control of the budget must be the responsibility of the head of department who makes a continuing assessment of the needs."⁵

Budgetary management, however, is becoming more complex and time consuming than it has been in the past, and the post-Griffiths developments require heads of departments to make a choice. Either they understand their budget, its allocation, and use, which means being able to read computer printouts sensibly and being able to understand the systems of costing tests sufficiently to subject them to critical analysis and amendment, or they do not. A head of department who delegates the responsibility for coming to terms with this work to his MLSO loses an important part of his managerial authority even if he retains the title because in a vitally important area of the department's management he is dependent on the skills of his MLSO. The document from the Royal College of Pathologists expects the head of department to invest some clinical

time in coming to terms with the responsibilities of resource management but not all consultants accept this even as heads of department. Some believe that they can escape this chore. Others believe on grounds of principle that their time should be wholly devoted to clinical work despite holding the title head of department. In either case the managerial competence in resource management is forced on to the MLSO and his authority in the department becomes greater as districts strive for effective budget control and cost containment. The variation between pathologists in their response to the job of managing resources across the country is probably greater than any other.

NEW TECHNOLOGY

Outside the immediate context of the Griffiths report's recommendations is the drive for cost improvement programmes as part of the NHS's need to use resources more effectively. New technology in the form of bedside pathology, the arguments in favour of large regional and subregional laboratories replacing district laboratories, and the West German experience of general practitioner laboratories are all threatening to change the traditional view of a district laboratory and its work. Even the success of the small, but growing, private laboratory services can be regarded as a technological challenge. So there is a growing awareness of major challenges which for many contribute to the existing state of unease and uncertainty and add to the complexity of any explanation about the present position in pathology.

STAFFING STRUCTURE OF THE LABORATORY

A separate development in the same category is the growing pressure to change the traditional staffing structure of the laboratory. Pressures for labour substitution are occurring in other parts of the NHS—that is, the replacement of highly trained and expensive skilled staff by less skilled and less expensive semiskilled staff who work closely under the supervision of a fully trained person. In pathology laboratories the pressure for labour substitution is being felt in the current Whitley Council negotiations to reintroduce or extend the category of laboratory aides or assistants not least as a reflection of the changing nature of laboratory work. As well as these negotiations some general managers want a more fundamental examination of pathology laboratory staffing, and voluntary discussions are already under way on the possible integration of professional and technical (A) scientists and Professional and Technical (B) MLSOs. These latter developments, coupled with the dropping of the principal MLSO posts in several districts and the lack of any overall staffing expansion in recent years, is contributing to unease, especially among MLSOs, and this in turn can make effective working relationships between consultants and MLSOs more difficult to achieve.

The experience of districts differs so markedly that it is dangerous to generalise about cause and effect of the current tensions in pathology laboratories. The uncertainty about how pathology services should be managed needs to be tackled first if laboratory departments and their managers and staff are to respond effectively to the challenges of resource management, cost containment, and new technology. Without a clear and authoritative management structure effective and coordinated responses to these other initiatives become much harder to achieve.

Views differ about the most appropriate management structure but the recommendations of the Royal College of Pathologists have most to commend them. In pathology the principal unit of management should be the department and not the laboratory. Many of the management problems caused by the two tier structure of management in laboratories are self inflicted wounds and have caused an increasing antagonism between professions that has nothing to do with the delivery of an effective clinical service. The Royal College of Pathologists has argued for the financial and status rewards to MLSOs to be based at departmental rather than laboratory level where the maintenance of a high quality professional role can be assured. The recommendations of the college, if carried out in every district, would undoubtedly diminish the role of cogwheel chairmen and limit them to their original representational and advisory role on behalf of their colleagues. It is inconsistent with the college's recommendations for the title of consultant in administrative charge to be continued, although this is in any case disappearing rapidly.

A managerial structure based on the department makes it more realistic for the managerial head to develop those general skills in management, and resource management in particular, that are now a necessary part of the management of the service. It is more realistic because they are based on a department whose clinical function is already understood and controlled by its consultant head. The crucial question, however, is whether district authorities, their district general managers, and unit general managers will allow this management structure to become dominant, given the present substantial variation of practice. Those who believe that the Royal College of Pathologists is right will have to fight for this outcome.

References

- 1 NHS management inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 2 Department of Health and Social Security. *Health service management: implementation of the NHS management inquiry report*. London: DHSS, 1984. (HC(84)13.)
- 3 Department of Health and Social Security. *Organisation of scientific and technical services*. London: DHSS, 1984. (HSC(IS)16.)
- 4 Department of Health and Social Security. *Remuneration, conditions of service and general information. Professional and technical staffs B Whitley council*. London: DHSS, 1986.
- 5 Royal College of Pathologists. *Management of pathology departments in the National Health Service*. London: Royal College of Pathologists, 1984.
- 6 Anonymous. Resource management initiative. *Br Med J* 1986;293:1320.

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Crown cars' agreement in Whitley Council

As reported recently (23 May, p 1364) there is an impasse in negotiations on improved mileage allowances for hospital doctors. The profession's negotiators have received an improved offer, which included a scheme for providing crown cars, from the Department of Health and Social Security but they decided that it was not wholly acceptable. That decision was reported to the Senior Hospital Staffs Conference (p 1624), which deplored the DHSS's delay in updating car allowances, and opposed any imposition of transport arrangements that had not been negotiated with the profession, and rejected the DHSS's proposals for crown cars for all doctors, insisting that they be provided only for those wishing to take part in the government's proposed scheme.

Meanwhile agreement has been reached in General Whitley Council negotiations, which cover other hospital and community staff including doctors in community medicine and health, for a crown car scheme and for increases in mileage rates. Under the new agreement the norm will be that if it is economic for the health authority to do so new employees required to use a car regularly on official business will be offered a crown car. Existing

employees, providing that they do not change their job, will be protected and can continue with the existing travel arrangements until they move or take up the offer of a crown car. If it is not economic to provide a crown car employees may use their own cars and receive regular mileage rates.

New employees who need a car and decline to take up the offer of a crown car will get public transport mileage only.

Employees with crown cars will be reimbursed for petrol in accordance with an agreed formula, and for parking, overnight garaging, tolls, and ferries. The crown car is known as the "base vehicle" and will normally have an engine capacity of between 1100 and 1300cc and not exceed 1800cc; though an employee can have a bigger car if he or she is willing to pay excess costs.

The outstanding revised mileage rates from July 1986 have now been agreed, and new rates have also been agreed from 1 January 1987. Both revisions are based, as previously, on AA schedules. BMA members may obtain details of the new arrangements from BMA House or BMA regional offices.