public the competence of doctors on its register the council should welcome complaints—because they provide one important means of detecting those doctors who are not competent.

LEGAL CHALLENGE TO THE GMC POLICY ON DIVERTING COMPLAINTS?

Because the council's policy of diverting complaints on medical treatment to the NHS is not written into the medical act it may be possible to challenge the policy in the courts—and win. This has not yet been tried.

Conclusion

This article has described what Mrs Robinson called “the first hurdle” in the GMC complaints machinery.¹ Three are still to come—the preliminary screener, the preliminary proceedings committee, and the professional conduct committee. These will be described in the next article; it is not difficult to understand why

Mrs Robinson and others use the image of hurdles; to reach the finishing post of serious professional misconduct is exhausting for both patients and doctors.

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- 2 Anonymous. GMC strengthens professional conduct procedure. *Br Med J* 1984;289:1325.
- 3 Walton J. A patient voice at the General Medical Council. *Lancet* 1987;ii:1312.
- 4 Robinson J. A patient voice at the GMC. A lay member's view of the General Medical Council. London: Health Rights, 1988.
- 5 Rosenthal MM. *Dealing with medical malpractice: the British and Swedish experience*. London: Tavistock, 1987.
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- 9 Campbell D. An investigative journalist looks at medical ethics. *Br Med J* 1989;298:1171-2.
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How To Do It

Be a manager

Cyril Chantler

There is no right or wrong way to learn how to be a manager, and in this respect management is quite different from medicine or science. My qualification for being asked to write this article is that I spent three years as chairman of our hospital board of management, with the title of unit general manager but without any specific training apart from reading a book while on a long journey before taking up my appointment.¹ I have read two other books since^{2,3}; Sir John Harvey Jones's *Making it Happen* I recommend to any clinician or academic because it emphasises the importance of leadership with its characteristics of imagination, courage, and sensitivity. Management is not the same as command or administration, but it requires characteristics derived from both. I am concerned mostly with the contribution that clinicians can make to the success of the NHS.

Qualifications

Many doctors have management experience, though they commonly discount this and spend little time analysing it. Most will have been required to organise activities on behalf of others at school, at university, or in practice. They are also experienced at making difficult decisions with inadequate information. They learn to live with the consequences while being prepared to accept that when they are wrong they must try again, driven by their responsibility for other people's lives and health. Sometimes they find it difficult to accept that management, like medicine, is an inexact science. At least as far as hospitals are concerned, management is important because doctors can serve their patients only if the resources are available and the whole team is organised to work at maximum efficiency.

Clinicians are natural leaders in a hospital. They, more than any other group, make the decisions that most affect the activities of the whole organisation. Consultants are usually associated intimately with a single hospital over many years. They are well educated and intelligent (intelligence being a necessary criterion for entry to the profession) and undoubtedly develop stamina in the early years after qualification. A

sense of humour, if not natural, is certainly a common defence against the tensions of the job. All of these characteristics are useful for a manager. Doctors and managers ought to be good listeners: attentive listening is essential for obtaining a clinical history from a patient, which enables the nature of a problem to be defined clearly in a relatively brief time. Doctors concerned with management are, surprisingly, not always as skilled as might be expected at counselling staff and making decisions that may affect employees profoundly. Sometimes a natural loyalty to people hampers decisions that are vital to a hospital. It is no use keeping people in jobs that are not necessary or in which their performance is poor; it is far better to help them by analysing their performance, providing motivation, retraining them, or occasionally allowing them to leave with proper entitlements.

Strategy and structure

It is always worth spending a great deal of time thinking and talking about the strategy of the organisation and making sure the structure is, or remains, correct. In 1984 Guy's Hospital was faced with a reduction in its budget of nearly 20% over eight years. The previous five years had been characterised by closures of beds, inadequate replacement of equipment, little expenditure on the infrastructure of the hospital, and falling morale with increasing antagonism between different professional groups. Consultant staff, angered by their inability to provide care and by problems ranging from lengthening waiting lists to the frequent absence of outpatients' records, made formal representations at all levels of the health service, and many of us took advantage of the proximity of Guy's Hospital to Fleet Street and the media to appeal to the public for more money for the hospital, but with little success. One consultant, however, succeeded in securing a donation to sustain his service for a year, and another set up an appeal fund that has provided over £250 000 yearly in revenue to support the children's unit.

The crisis encouraged a deep analysis of strategy and structure. The most important question to be

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answered was whether clinicians should be concerned with the management of hospitals. The important characteristic of an NHS hospital is that it is cash limited, unlike a private hospital, in which income is related to activity. Clinicians need resources if they are to have clinical freedom. An authority that is cash limited will not transfer responsibility for management to a group that refuses to accept financial responsibility, nor will it readily accept or act on advice from a medical advisory committee if the members of the committee are not financially aware or accountable. After much debate the clinicians at Guy's Hospital reached an agreement with the district health authority whereby they would accept financial responsibility and accountability in return for management authority. Parenthetically, they also realised that if they could show that the hospital was efficient they would have a stronger voice in determining the allocation of resources at all levels in the NHS. There are, however, four principles that in our opinion govern the participation of clinicians in management.

PROFESSIONAL AND MANAGEMENT ACCOUNTABILITY ARE DIFFERENT

Unlike staff in most organisations, hospital staff are drawn from members of several very different professions. Nurses, administrators, scientists, engineers, catering staff, porters, accountants, personnel officers, clerical staff, and doctors all have their own professional organisations that determine training and set standards and to which they are accountable. Traditionally, hospitals have been administered by a trio of a doctor, a nurse, and an administrator, with help from other professional groups. The head of each professional group is concerned largely with the performance of his or her own department or function and has only a secondary concern for overall management, rather like a first violin player in an orchestra with no director or conductor. General management has to be seen in the light of the many different professional groups that comprise the staff of a hospital.⁴ No one person can hope to understand, let alone lead, such an organisation. Mr Enoch Powell remarked recently that the Minister for Health has to accept advice from doctors without question whereas the Minister for Defence can contradict his generals.

Professional accountability must be protected, and certainly no interference by management in the care of a patient can or should be tolerated; the first responsibility of a doctor is to the patient. Management accountability is separate and different. The public has the right to know that the resources provided by taxation are being used efficiently and effectively and that everyone in the organisation is accountable managerially. In our structure staff continue to report professionally and are accountable to their seniors; thus all nurses are accountable to the director of nursing. Managerially, the final responsibility is held by the chairman of the board, who is a doctor, and the nurses, administrators, etc, are accountable finally to him; he in turn is accountable to the district general manager and the district health authority.

RESPONSIBILITY AND AUTHORITY MUST BE COMMENSURATE

Large hospitals are too complex to be managed centrally. We decentralised to 14 clinical directorates, each managed by a team of a nurse and a business manager and headed by a doctor. Each directorate manages its own affairs as far as possible and has its own doctors, nurses, clerical staff, scientists, technicians, records staff, etc. Each has its own ward or wards and organises its own admissions, outpatients, etc. Two thirds of our staff now report within these directorates. Budgets are set yearly, and there is a

requirement to meet agreed targets of quantity and quality for patient care within the financial provision. Responsibility that is decentralised, however, must be accompanied by the transfer of authority. If power without responsibility is dangerous then responsibility without authority is demoralising.

Lines of accountability should be as short as possible. The Salmon structure for nursing with its inbuilt "Chinese whispers" reduced the authority and managerial competence of ward sisters. In our structure clinical groups led by the ward sister and consultant have their own budgets and report to the clinical directorate concerned.

PART TIME COMMITMENT

Clinical practice requires practice, and clinicians in management should continue to maintain clinical duties for the benefit of their own professional futures and satisfaction and because they can bring their unique perspective to management only if they continue to be active clinically. Management and administration should not be confused. The clinician manager needs an administrator, who should be a colleague whose professional skills are valued. The relationship between the manager and the administrator can be viewed as similar to that between a minister and a permanent secretary.

INFORMATION AND BUDGETING

Good management needs good information—for instance, I was taught that the first action to take when a patient with diabetic ketoacidosis was admitted was to telephone the staff of the clinical chemistry laboratory and enlist their support. Good management, however, also depends on doing the best you can with the information available. It is no use providing sophisticated information or clinical budgeting systems if there is no management structure that can use the information. Our policy has been to concentrate on getting the structure right. The new management board at Guy's Hospital, which started working in April 1985, inherited a yearly rate of overspending of about £5m. This was tackled by recognising that 60-70% of expenditure was on staff costs and that the key pieces of information that we lacked were how many people we employed and how much they earned. Overspending is best approached by reducing costs and then allowing activity to adjust rather than the reverse. Having identified the role of each employee, we then reduced staffing by about 10% over six months while doing our best to protect clinical activity. One of the key tasks of the NHS is to regain the post-1948 enthusiasm for treating as many patients as possible to an acceptable standard rather than being led by the need to balance the books. Balancing the books is essential but is not the purpose of the service. In the past three years we have reduced staffing by about 17% and expenditure by 15% (£7m yearly) but last year we treated nearly 40 000 inpatients—almost as many as ever before.

Accountancy in the NHS is traditionally functionally based; thus nursing staff, medical staff, clerical staff, maintenance, and catering all have budgets even though they are mostly unmanageable by any one person. Reorganisation into multiprofessional management groups must be followed by management accountancy so that each of these groups is provided with accurate information concerning income and expenditure. The NHS should change from functional to management accountancy urgently. It takes time to set up these new systems, and the quality of the information improves only after an iterative process between the finance department and the manager. We hope that by October 1989 our clinical directorates and ward based clinical groups will receive monthly state-

ments of expenditure set against budgets for staffing costs, other expenditure in the central sterile supply department, stores and supplies, drugs, repairs and maintenance, and consumables in pathology and radiology departments. The possibilities for improving efficiency should not be underestimated: a ward sister recently saved £5000 in nursing costs and £1300 in consumable costs on her ward in one month.

Quality

As long as patients cannot receive the treatment they need when they need it quantity must remain the most important aspect of quality in the NHS, but it should not be an excuse for poor quality. Improving quality can save money and improve clinical efficiency and effectiveness. Our decentralised outpatient appointment system, run by each firm's medical records officer and clinic clerk, has led to better spaced appointments with reduced waiting times, less crowding, and, therefore, less pressure on the staff, no missing notes, and no fewer patients. Preadmission clinics for surgery with regular reviews of waiting lists can lead to fewer operations being cancelled. High occupancy of beds does not necessarily mean higher patient throughput, and we all know hospitals where patients are admitted early simply to "protect the bed." These are all things where only the doctor "can reach the parts that other managers fail to reach." Medical audit or clinical review should also be encouraged as a means to improve clinical efficiency as well as effectiveness.⁵

Time

A common argument used against concerning clinicians with management is lack of time: it is worth asking, How much time is spent in committees? and Is this effort productive? Using your own and others' time efficiently is an essential quality of management. Much can be achieved by a telephone conversation, by being rigorous about reading and keeping only essential material, by not having continued minutes, by stating when a meeting will end as well as when it will start, and by delegation. Again, however, it should be emphasised that time spent in determining operational policies is seldom wasted, and a well organised clinical service will release time and resources for caring for patients. Management time for clinicians can often be created outside clinical sessions: surgeons like to meet before breakfast whereas physicians seem to prefer to meet before dinner; lunchtime is a good time to meet the non-clinical staff.

Listening

As a manager it is easy to become desk bound and concerned with details to the extent that the main tasks pass you by. You should try to ensure that you keep definite periods free for visiting all parts of your area of responsibility—"the best manure is the farmer's feet"—and you may find that visiting people in their own departments rather than meeting them in your office is useful and helps to put a problem into its proper context. You should be available to offer advice when problems occur, and in the long run this can save a lot of time for yourself and the whole organisation. Dealing with mail efficiently and promptly is important, and generally I tried to ensure that my desk was clear at the end of each day.

Decisions and leadership

A good manager has to be decisive; but not all decisions will be correct for whatever reason, and there

is often no harm in admitting that you were wrong and trying again. A good decision will command support among all those who have to implement it, and, indeed, they should have helped in formulating it. Often a properly led discussion will produce an obvious decision, at other times competing priorities will preclude a consensus, but the decision, once made, will still be carried through as long as everyone is satisfied that it has been properly reached.

A clinical manager has an important leadership role. Leadership implies that there are those who are prepared to follow. The clinical directors at Guy's and the chairman of the board are appointed not elected, but if it is clear that they have lost the support of their colleagues they have little option other than to resign and be replaced. Checks on the possible abuse of authority are important, and the British system of all consultants being created equal is too valuable to discard.

Incentives and motivation

The main defect of the NHS is the lack of incentive to good performance at all levels. Far too many people earn far too little and work far too ineffectively. We need the freedom to pay people according to performance and can look to do so by using the resources released by employing fewer people. Even under the present system a little imagination can be helpful, but changes in the all embracing and suffocating Whitley system are required urgently. A system is also required to make sure that efficient and effective hospitals and services are rewarded with more resources. Indeed, if under a cash limited system resources fail to follow the patient then the NHS will inevitably stop being national. A good manager will be looking for ways to increase motivation and should not underestimate the devotion to patient care of all staff in the NHS. Most people who work in the service are proud of it and are underappreciated; showing that you, the manager, appreciate their efforts is vital.

Everyone in the organisation should understand their job, should know to whom they report, and should have their performance reviewed regularly to provide motivation, advice, and help. The flow of information up and down the organisation can be improved by a system of team briefing.⁶ Social occasions are important, and an occasional chat over a drink can often be invaluable.

Uncertainty or hostility is often caused by re-organisation of office, clinic, or ward space. None the less, it is vital that staff in management teams work near each other so that communication is facilitated. Key staff in the central management such as the clinician manager, chief administrator, director of nursing, financial director, and personnel director must have their offices near each other.

Training

I have already suggested that clinicians have more management experience than they might realise. They need to have a general appreciation of how the NHS works and the roles and skills of other professionals. Much can be learnt from informal discussions with finance staff, administrators, and personnel officers. Courses such as those run by the King's Fund College, the Royal College of Physicians, and the NHS Training Authority can be useful not only because of what is taught but also for the chance to meet others with similar responsibilities and to reflect on problems. They can also be useful in developing interpersonal skills and techniques for solving problems. Imagination is vital for solving problems but needs to be stimulated. Occasional sessions spent with colleagues

in management, preferably in the evenings or off site so that interruptions are minimised, are useful to work out tactics and strategy and are usually educational. There is no body of knowledge, such as is required for a medical qualification, that has to be gained by a clinician for management; thankfully, too, there are no exams worth taking, and we should restrict their creation.

Conclusion

This is a critical time for the NHS. There are forces pressing for changes either to create more bureaucratic and political control or to move to a market dominated system that is provided privately though subsidised publicly. I favour neither of these options, but I think that the service needs to be managed more competently. It is in the interests of patients as well as doctors that clinicians should participate in the management of their hospitals. A

team approach that uses the skills of other professionals and shares the responsibility for management with other clinical colleagues by decentralisation offers the opportunity for clinicians to be managers without making it impossible for them to pursue clinical or academic practice. The NHS needs more money and a greater share of the national revenue. We are more likely to obtain this if we can show clinical efficiency and effectiveness and maintain the support of the public by providing a more personal and convenient service.⁷ Management is too important to be left to others; doctors must play a part.

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Green College Lectures

The responsibility of the media

Zelman Cowen

As chairman of the Press Council for five years up to October 1988 I have had a special and continuing concern with matters that bear on the responsibility of the press. The Press Council came into being in 1953, after a recommendation four years earlier of the first royal commission on the press. That commission was set up because of expressions of parliamentary concern at the growth of concentration in the control of the press, as well as at press standards. It recommended the establishment of a council to take appropriate action "to safeguard the freedom of the press to encourage the growth of the sense of public responsibility and public service among all engaged in the profession of journalism."

The two subsequent royal commissions on the press, in 1962 and in 1977, both examined the Press Council and its workings and made criticisms and recommendations for its more effective operation. These recommendations, together with proposals made by the Younger committee on privacy in 1972, have largely been adopted by the council, which operates as a non-governmental, non-coercive body without any legislative backing and is financed voluntarily by the press. Its contemporary constitution gives expression to obligations to preserve the freedom of the British press, to maintain its character in accordance with the highest professional and commercial standards, to consider complaints about the conduct of the press or the conduct of others towards it, and to deal with complaints in a practical and suitable manner. It is required to review developments likely to restrict the supply of information of public interest and importance and to report publicly on developments towards greater concentration on monopoly in the press.

Freedom and responsibility

The Press Council has acted to discharge all these obligations, but in practical terms it has been principally concerned with issues that bear on press responsibility, with the maintenance of standards, and in particular with the adjudication of complaints about press conduct. It does so within a framework of purposes

concerned with both the freedom and the responsibility of the press. It has been asked whether the notions of freedom and responsibility are not in tension, so that there is incompatibility in the discharge of functions pulling in opposite directions. I believe not: it is well said that a powerful consideration in constituting the Press Council was to raise the general standards of performance in exercising the freedom that the law allows to the press by constant insistence on high ethical principles and, by doing so, to preserve public regard for that freedom for the sake of the press and ultimately for the sake of the people.

The council has operated in an atmosphere in which issues touching the press and the media more generally have been a matter of continuing public concern. That is evidenced by the setting up of no fewer than three royal commissions on the press since 1947 and by the constitution by the government of committees concerned with privacy, defamation, contempt of court, and official secrets, all of which have dealt with press responsibility. As well as press and media issues, the role and performance of the Press Council itself have been a matter of continuing public discussion. In the past year or so general and particular issues have been debated in both houses of parliament. In the House of Lords we have the testimony of men such as Lord Deedes, a former editor of the *Daily Telegraph*, that the standing of the national press is "at a very low ebb—perhaps the lowest I have known in about half a century of journalism." In 1988 private members' bills proposing statutory protection for privacy and "right of reply" legislation were introduced with substantial support; and these initiatives will be renewed in further bills this year. In all of this there is a repeated concern—expressed also by government ministers—at low press standards of responsibility, and discontent has been voiced with the performance of a Press Council that lacks coercive authority and power to impose sanctions and obligations.

In all of this I speak particularly of the press and not about other media. This is not intended to represent a judgment about the importance of print as compared

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