A BMA secretary for quality

Richard Smith

ADRIAN STEVENS

Mac Armstrong: "Improved quality of patient care is the best argument you can ever use."

Ernest McAlpine Armstrong (known to all as Mac) will be the next secretary of the BMA. Currently 47 and chairman of the Scottish council of the BMA, Mac has been a general practitioner in the Highlands since 1975. He spoke to Richard Smith last week about his plans for his secretaryship.

RS: What are the main issues facing the BMA?

MA: The main issue is how to respond to an environment of constant change in health care.

RS: So the BMA must become an organisation that can make faster, better decisions?

MA: We must become much more forward looking—because part of the process of managing change is to understand and anticipate it. We must be there before the change takes place.

RS: How can that be achieved?

MA: We have to have a strategic view. There's always a place for the quick response team, and doctors in clinical practice are well used to that. But the BMA also needs a strategy, and I think it's the job of the secretariat to provide that view, to see the issues before they come up, and to prepare for them.

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RS: Should the secretariat do that on its own and present the elected members with its thoughts, or should it work with the elected members?

MA: As the secretary I will be entirely at the disposal of the elected members. There is a leadership role, but in this highly democratic organisation the elected members must take the main lead. But I have to make sure that when they make a decision they make it on all the facts and with as broad an understanding as possible. And if they make the wrong decision it will be partly my fault. I cannot stand back from any decision that's made.

RS: It's for you to lead by guiding?

MA: Let me put it this way. There's a concept around that there's no such thing as society but only a collection of individuals and that there's no such thing as the BMA but only the members. I completely disagree. I think that there is more to the BMA than just the members: there has also to be a philosophy, an outlook, and a faith, a belief in what we are doing. The BMA is more than the sum of the collective experience of the individual members. The secretary has to contribute to making the sum of the BMA bigger than its individual parts.

Quality is the key issue

RS: What is the BMA about? Is it about making sure that doctors have the best possible terms and conditions of service? Or is it more than that?

MA: It's much more than that, but the broader role and the narrower role go in tandem. The watchword that I have picked for my term of office is quality. Quality is the key issue. Quality matters both in respect of quality in health care—and I think that quality in health care is going to provide all the key political issues in the next few years—and in terms of the BMA's service to its members.

"The watchword that I have picked for my term of office is quality."

Let me explain what I mean by quality. Quality is a personal responsibility: it's never being satisfied with the way you do things. It's saying "No matter how well I do, if I think hard enough I can do better."

That's important for the BMA. Many of the things we do are excellent, even world class. But I think we could do them all better. We do a lot of things because that's the way we've always done them. We need to re-examine those things and develop—from the bottom up—a culture of quality. Everybody in the organisation needs to know that their contribution matters and that if they do it a little bit better then everything is made better.

Improved quality of patient care is the best argument you can ever use. It doesn't matter whether you're talking about the conditions of consultants, medical education, the role of public health doctors, junior doctors' hours, or out of hours work in primary care. If you can say that a change will improve the quality of patient care it's a strong argument.

So far debate has centred on only two of the three arms of what might be called the health care triangle. We've talked about overall resources and about priority setting in how much we spend and what we spend it on but not about the quality of what we buy. That's been left to us, the profession, so far. But that's about to change. Managers now have an interest in audit, education, accreditation, guidelines, and outcomes—all the issues that we used to feel were entirely professional. Management has a justifiable interest because it reflects on the other two legs of the triangle. That is a threat to us but also an opportunity —because the BMA is the only organisation that can bring together the various players such as the crafts and the colleges, doctors, and other health professionals.

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Our roots are firmly founded in science and education, and our members need to understand these issues of quality in health care. We must help members from one discipline understand the problems of those in other disciplines.

RS: Does the message on quality apply to the staff, the elected members, ordinary members, or everybody?

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MA: Everybody. The secretary has various constituencies: the public, the politicians, the ordinary members, and the staff. We have a large and superb staff. But we must improve our services to members—because there is a lot of competition out there. The only way we are going to keep our members and improve our membership figures is by reaching out to them. Some groups—junior doctors, for instance—we have to reach out to right now.

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RS: How?

MA: When developing a strategy there's a terrible temptation to make a list of all the things we do, then list the different categories of membership across the top and create a series of boxes. But such an approach is bitty. It doesn't have any pace. And there's no message to it. The result is often to think "Well, 80% is pretty good. We don't need to do too much about that." But the message I want to get across is, "How can we make every box better?"

RS: Does that mean that the BMA needs all the boxes? Is there no need for a major re-examination of what the BMA is doing?

Strengthening local representation

MA: We must examine all the boxes. We certainly have to address the organisation of regional services—because within a year 90 plus per cent of all NHS units will be independent trusts. And within that context the current structures we have are relatively meaningless. New structures are being forced on us. Local negotiating committees have to be the way forward. But how do they relate to the structures we have now? What relevance do the central committees have if decisions are being made in the periphery?

RS: What relevance do they have?

MA: They have enormous relevance—as a reference point and a resource.

RS: So, they'll have to continue to meet—and as often as they do now?

MA: That's a different question. If we ask how can we do better the answer might be to meet less often.

RS: Will this shift to regions have to happen fast?

MA: It will, but the strategic approach will help. One way to approach the problem is to say, "We've got a problem with our structure here in, say, Blankshire. We've got all these local negotiating committees. We've got divisions, and we've got people going up to London. How relevant is it all? How can we make it more relevant?" We must then go back to our strategy. We are about improving the quality of patient care, and so we must ask what sort of structure we need to achieve that. Doctors need to relate to each other to improve that care. We must keep coming back to the reference points—to improve the quality of patient care, the quality of doctors' lives, and the quality of services to BMA members.

That might mean we do it differently in Blankshire, Birmingham, or the Western Isles. But if the outcome is better patient care you're on the right track.

RS: So there will be a lot of decentralisation?

MA: There must be. We have to be prepared for a tremendous amount of flexibility.

RS: But are we?

MA: Frankly, no. There is a lot of inertia in the system. But what am I going to do as secretary? I can only do what the members let me do.

RS: So we are sitting here in this £60m house. Is this how it's going to be in five years' time?

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MA: We took the decision more than 10 years ago to develop regional services, and that was one of the most far sighted decisions we ever made. So we had some sort of structure on the ground. But—as in so many professional practices—we need critical mass. Doctors are at their best when they work together and at their most vulnerable when they work in isolation. So we do need a central organisation that has enough critical mass and energy to feed out into the periphery. We allow the central organisation to atrophy at our peril because the ability of the peripheral organisation to sustain itself independently would be poor.

RS: So you see more people in the periphery but not necessarily fewer at the centre?

MA: That's a matter I'll be picking through as time goes by.

The future of divisions

RS: What about the bits of the BMA we have at the moment? What about the divisions?

MA: The divisions are clearly facing their biggest challenge ever. Some divisions function actively and are well placed to fulfil the coordinating role that is about to fall into their laps. But others are not well placed. And one of the biggest threats we face is that we become divided. It's in management's interest that we work apart. They want to set Dr A against Dr B, but we know from 2000 years of history that the patient gets the best deal when doctors work together.

The BMA is unique in being the only organisation in Britain that has the potential to fulfil that role. And the divisions are tailor made to fulfil the role. But the question is whether by reperfusing an atrophied organ you can regenerate it.

RS: You mean there may need to be another organ?

MA: Exactly. In some places there may have to be a new

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structure. The BMA has to be able to cope with a variety of coordinating structures under different names.

RS: So instead of there being a division everywhere there might be divisions in some places and some different sorts of structures in other places?

MA: Yes. We cannot be hard and fast about the shape of services we have in any locality. The relatively rigid barrier that we've always had between primary and secondary care is about to come tumbling down. Doctors and resources are going to move in both directions. It's a very confused situation. So for the centre to be prescriptive about the representation in any locality—saying you must have so many consultants, so many general practitioners, so many juniors—is inappropriate. Representational structures have to reflect the organisation of care in that locality.

Another particular problem is bringing public health into all this. Public health currently sits very uneasily between purchaser and provider, and the professionalism of public health doctors is something we have to tap into. The BMA is the only organisation capable of doing that.

RS: So all this change presents a lot of opportunities to the BMA?

MA: Yes.

Balancing crafts within the BMA

RS: What about the tensions within the BMA? It's sometimes seen as a weak federation with most of the power residing in the crafts. Are the balance and the mechanisms right?

MA: No. We have to constantly change them. What would be the sense in saying that any of the craft structures are fossilised? It might be that changes in the health service mean that we may need multicraft central committees. Take the field of primary care. What is it? Or what is secondary care? It's much less clear than ever it was. We don't have a forum in which we can discuss primary care and take account of the fact that many specialists are now practising in what was previously a primary care setting. We don't have any forum that takes account of the dramatically changing structure in hospitals. I don't see any of our central structures as fixed.

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RS: Might it be that the BMA becomes stronger and some of the crafts weaker? Or is that oversimplifying?

MA: I think it is. I don't see this as in any way fixed. I don't think that it's my job as secretary to have fixed ideas. It's my job to put the questions to the elected members. They must decide.

RS: What about the annual representative meeting?

MA: Is the ARM as good as it could be? It's a showcase. Every year the world looks at the BMA for a week. What an opportunity. I simply ask "Could it be better?"

RS: You've just said "Everything could be better."

MA: Exactly. I believe it could be better. But the ARM is not mine. The members must decide.

Relations with government

RS: What about relations with government? Could they be better too?

MA: The fact is that the BMA is not government. And this is a democracy, which means that the government could change tomorrow. It therefore behoves the BMA to stick to its own strategic initiatives. Government objectives are always short term, ours are long term.

RS: But what about *The Health of the Nation*?

MA: *The Health of the Nation* is a very positive initiative, and we've responded well to that. It's astonishing that we've staggered through 44 years of the NHS without strategic direction. What are we trying to achieve?

RS: Is that an example of where the BMA can support government objectives?

MA: Yes. Because *The Health of the Nation* is about improving the quality of patient care.

RS: When you look back over 20 years how do you think the BMA has done?

MA: I think we've done well. But we have to be prepared to take a humble view. I was looking at a *BMA News Review* of 1976, and it contained articles on junior doctors' hours of work, problems in inner London, and out of hours care by general practitioners.

"We have to be prepared to take a long view."

These issues are going to run and run. We have to be prepared to take a long view.

RS: Do you think that the BMA has the influence now that it had 20 years ago?

MA: Yes. We mustn't sell ourselves short. The fascinating thing to me is that the further away you get from the BMA the more valued it is.

RS: Maybe that's because the closer you get the shakier it seems.

MA: I don't think so.

Partnership, enthusiasm, and credibility

RS: What are the particular strengths you bring to the job?

MA: I have three things that I will fall back on. Firstly, the tremendous privilege of working in general practice has taught me about the value of partnership. I'm not used to working in hierarchies. I treat people as partners. I want to develop the idea of partnership and teamwork in health care.

Secondly, I will fall back on enthusiasm. I really enjoy being a doctor. I've enormously enjoyed being a general practitioner.

Thirdly, I've been lucky not to acquire the baggage of cynicism that many of my colleagues get burdened with.

I've experienced the organisation from top to bottom, and I've got the credibility. What the BMA needs at the moment is a doctor as a secretary who's absolutely committed to the interface between doctor and patient.

RS: You think you can manage the transition from being an elected member to an employee without difficulty?

MA: Yes.

RS: Finally, will you stay until you're 60?

MA: Yes. I'm looking forward to it—not to being 60 but to being different at 60 from how I am now.