Doctors becoming managers

A conversation among Richard Smith, Sir Anthony Grabham, and Professor Cyril Chantler

The pressure is growing on hospital doctors to participate more in managing the health service, not least from the government's review of the health service. Below Richard Smith, assistant editor of the BMJ, discusses the issues raised by doctors participating more in management with Sir Anthony Grabham, a former chairman of the council of the BMA, and Professor Cyril Chantler, a paediatric nephrologist from Guy's Hospital. Professor Chantler has played a leading part in the management revolution that has meant that since 1983 Guy's has cut beds by 28%, expenditure by 15%, and staff by 17% and yet treated just about as many patients as in its record year of 1982.[1]

RS: You both believe that hospital doctors need to participate more in managing the hospital service. Why?

CC: Doctors must play a bigger part in managing the health service to protect their clinical freedom. In a cash limited health service like ours authority to allocate resources will be given only to those who are willing to take financial responsibility. Doctors must therefore manage or their control of resources will be reduced—and if you don't have resources you don't have clinical freedom.

A secondary reason why doctors must participate in management is that in most hospitals they have been around much longer than anyone else (and certainly longer than most administrators) and have some vision of where the hospital is going. In addition, their immediate contact with patients means that they know better than anyone else what matters most.

AG: I largely agree with that, but I want to give the problem a longer perspective. Before the Griffiths reorganisation doctors had much more to do with management. Since then they have been put on one side and absolved from taking many of the difficult decisions, and some doctors have indubitably been only too happy to put down what is a heavy burden. Doctors would thus be giving something back to the health service if they were again to take a bigger part in management, and in return we would have more control of our destinies and those of our patients.

The other major point is that doctors are potentially the best managers in the health service. They have the longest and best education of all those in the hospitals, the most experience, and are responsible for most of the decisions that lead to expenditure.

The principles of management by doctors

RS: How might doctors play a larger part in management?

CC: Each district and hospital will want to work out its own way of incorporating doctors into management, but there are, I think, four important principles that should be followed.

Firstly, doctors must do the job part time—perhaps for about three sessions a week. To be competent at clinical practice you must keep at it, and if you don't then not only will you have problems of re-entry after finishing your spell as a manager but also you may lose the support of your clinical colleagues—and that is vital. Doctor-managers must realise that they are there to manage, not to administer, and they thus need the support of administrators who understand the daily business of running the hospital. It is like the relationship between a managing director and the chairman of the board or between the permanent secretary and the minister, with the doctor-manager as the minister.

RS: Might that not mean that you run into the problems depicted in the television series "Yes, Minister"—that is, that you don't know what is going on because the administrators keep you ignorant so that they keep the power?

CC: Potentially it might, but it shouldn't. Management is not about giving orders but rather about finding areas of agreement so that you can move forward.

The second important principle of doctors working as managers is that they must understand that managerial and professional accountability are different. Thus nurse-managers are professionally responsible through their hierarchy but managerially responsible to the general manager. This provides a system of checks and balances so that if a nurse-manager is unhappy with what a doctor-manager is doing she can go to her own hierarchy.

RS: Mightn't this undermine the doctor-manager's ability to manage?

CC: It might, but it hasn't actually happened at Guy's. I don't believe in the lowest common denominator system of consensus management, but I do believe that you must encourage everybody to go with you when you make a change.

RS: Might there not be conflicts between your management and professional responsibilities. For instance, as a manager you might have to reduce the number of people receiving dialysis to stay within your budget, while as a doctor responsible for an individual patient with renal failure you want to do everything to ensure that he or she receives dialysis.

CC: This can be a problem, although it hasn't been. I strongly believe that a doctor's first responsibility is to his or her patient and not to the NHS or the hospital. Yet you have to work within the resources available. But you must recognise that there will be conflicts when resources are not available, and once you have recognised it you are half way to dealing with the problem.

The third principle of doctors working as managers is that responsibility and authority must be commensurate with each other and they must be delegated as much as possible. Power without responsibility is, as Rudyard Kipling said, "the prerogative of the harlot throughout the ages," but responsibility without power is just as impossible. And within a large organisation you need to decentralise as far as possible to the people who are actually doing the work. Thus we've created 14 clinical directorates at Guy's, and the directorates have their own staff from all disciplines, including records staff, and beds; about two thirds of the staff of the hospital report within the directorates. We're now looking to take that down to ward level.

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The fourth principle is that managers must know how much things cost. You must know, for instance, how many people you employ and how much they are paid—simple information. I believe that the accountancy system in the NHS must be changed. At the moment it is done by functional group—doctors, nurses, porters, etc—but these groups are unmanageable: a senior nurse cannot manage a thousand nurses. What is needed is an accountancy system that is based on a management budget. And you can do that easily: you can buy the systems off the shelf.

RS: How do you, Sir Anthony, react to those four principles?

AG: I accept largely the first three. Once we have agreed the general principle that doctors should play a larger part in management the details can be worked out later, centrally and locally. I haven't examined the Guy's system myself, but the reports I hear are favourable, although people have observed that the Guy's project may have worked so well because the hospital had so much fat to begin with.

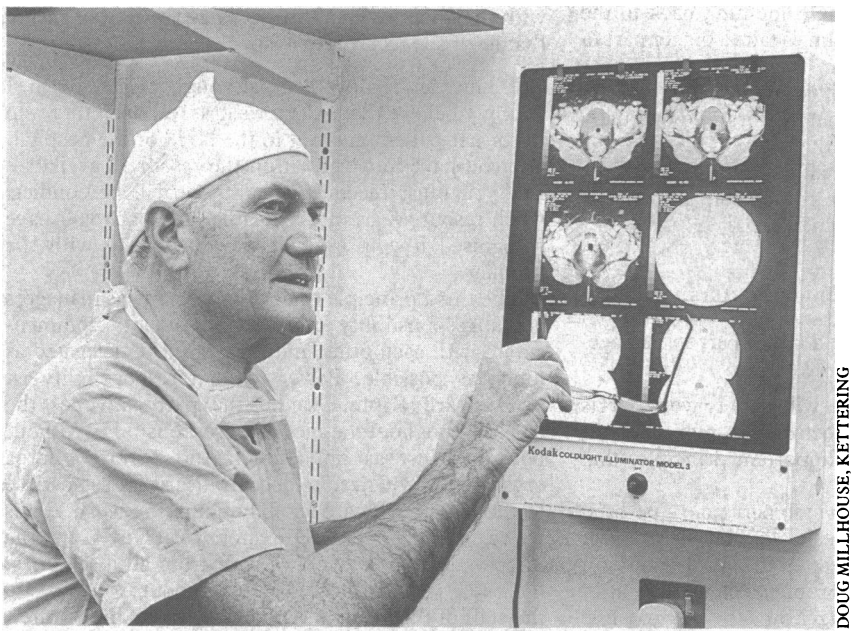
CC: That's a reasonable observation, but I don't think that it's the whole truth.

AG: I also observe that Cyril, like others, says that he still rejects consensus management but then is accepting that some sort of consensus management is essential in practice.

CC: Absolutely. I'd point out to you the message contained in the best book I know on management—*Making it Happen* by Sir John Harvey-Jones, who was managing director of ICI.[2] He was in the navy until he was about 40 and then whizzed up the management structure at ICI. Command and management are not the same thing, and he repeatedly emphasises that you must spend a lot of time discussing any change you are proposing with everybody who will be affected. Then people are more likely to cooperate with the final decision even if they are unhappy with it. To me that is consensus—a proper management technique.

AG: I accept that if there is conflict then at the end of the day somebody must make the decision, but surely we are not going to put our health authorities into a position where they, rather than the professions, make decisions.

I am less happy with Cyril's fourth principle: we must have information, but I believe that we may be in danger of being drowned in meaningless data. Information is expensive, and I question that we need some of the elaborate systems that are proposed. We're not in the business of detailed costing of cans of beans; we want broader basic information. We don't really yet know how much information we need for effective management of resources.



DOUG MILLHOUSE, KETTERING

Sir Anthony Grabham, consultant surgeon in Kettering

How much information is needed for good management?

CC: I have sympathy with Tony's view on information: we don't know how much we need. We do have an unlimited capacity to produce data, and the data themselves create work—somebody has to look at them. When I was the unit general manager I quickly learnt to use my wastepaper basket as a filing system. Otherwise, I would have been destroyed by the weight of data.

I think that information within the NHS is almost out of control. What we need to decide is what are the key pieces of information that we need to manage the health service, and that is what every hospital should collect. And they need to be the minimum data.

I don't yet know what those minimum data are, but I think it is an urgent task for the NHS to find out. At Guy's we collect information for clinical teams on manpower, drugs, and medical and surgical supplies, and on the variable element of radiology and pathology. Whether those are the right pieces of information I don't know, nor do I know whether we will need more, but they seem to comprise the commanding heights of the economy of a hospital.

AG: I think that most doctors are pretty efficient at the moment, and I don't think that breaking down costs onto a computer will necessarily make us more efficient.

CC: I disagree. I can think of an example from my own ward. One of our sisters calculated that we would save money if we scrapped all five of our peritoneal dialysis machines, which cost about £5000 each. I was astonished when she suggested this, but she was right because buying new machines cut our running costs by £22 000 a year. I think that there are many other examples like this.

AG: I think that this is an example of a sensible decision made by an experienced clinician rather than the result of complex information kept on a computer.

RS: What about information on outcomes? How much of this do we need?

CC: There is a problem about measuring outcome, but as with other information we must decide the minimum amount that we need to know: we certainly need some information on outcomes, but we don't want to be lost in a welter of bureaucratic information that doesn't actually help us.

AG: The experience of the United States seems to me to bear this out. They have gathered masses of information—for instance, on diagnosis related groups—that they cannot use effectively.

CC: What I think we should do is to go to the doctors themselves and ask them what are the five pieces of data that they would gather to show how well or badly they are doing.

RS: Have you done that?

CC: Not yet, but we hope to.

AG: Let's ask Cyril what are the five pieces of

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Professor Cyril Chantler, professor of paediatric nephrology, United Medical and Dental Schools of Guy's and St Thomas's Hospitals, with Sister Maggie Hicklin

information he would gather in his specialty [paediatric nephrology].

CC: I'd do what we already do—that is, measure graft survival, patient survival, rejection rates, and the complication rate after transplants. These are the key things we need to know about a transplant service.

Problems of doctors as managers

RS: Let's now look at the problems of doctors working as managers. You've given us your views, Cyril, on the tension between a manager's responsibility to a community and to keeping to a budget and a doctor's responsibility to the patient in front of him or her. What do you think about this, Sir Anthony?

AG: Most doctors do not at the moment have any real responsibility for management and simply concentrate on doing their best for the patient in front of them. Once doctors truly become part of management and are working within limited budgets then they will be willing to do their best within the budgets for all their patients. But—and this is the difference between the doctor-manager and the lay manager—the doctors are better placed to be able to say that resources are now stretched too thin and that they will not accept the budget. The lay manager is much more concerned about protecting the budget and is less willing or able to stick his neck out. That is the main difference between the two sorts of managers.

RS: So, Cyril, has that happened at Guy's?

CC: It has happened the other way round in that clinical directors have said that within the budget you have given us we will not be able to treat as many patients as we believe should be treated: you as managers must make it clear that you take responsibility for that.

RS: What about the problem that the time of doctors is taken away from patient care, for which they have been trained, and devoted to management?

CC: The first thing that I have to say is that management is too important to be left to others. And then doctors who are not managers spend large amounts of time in administration—sitting on committees that are further and further removed from the running of the hospital. Views are stated, but action doesn't follow.

AG: I don't think that doctors having to spend time on management is a problem. We must have good management, and doctors must play a central part.

Consultants confronting other consultants

RS: What about the problem of a consultant who is a manager having to tell another consultant what to do?

CC: This has not been a serious problem at Guy's, and I think that we hear far too much from the media these days about consultants not pulling their weight. Most are doing much more than they are contracted for.

RS: What if you are confronted, for instance, with a consultant who consistently turns up late for out-patients?

CC: The first thing to do in such circumstances is to check the facts. I dealt with one consultant who always arrived at 3 pm and could not arrive earlier, and what I discovered was that he always stayed until 7 pm. I persuaded the staff to book his first appointment at 3 pm and explained to him that he would have to do the last two hours of his clinic without nurses. He accepted that and had, indeed, been doing it for years.

Sometimes, however, there will be a real problem. Then you must talk to the consultant and ask him what he intends to do. He has three options: to change; to renegotiate his contract; or to leave. But consultants having to confront each other is not a big problem. I don't know why such a fuss is made about it.

AG: The problem that we have more often is to stop people doing too much—to stop surgeons operating too long. That may be very difficult.

CC: We've had that too, and again we've solved it by discussion. One of our newly appointed surgeons did an effective but very expensive operation. We financed him until it was clear that the operation was successful and then discussed how many operations we could afford. We funded up to 40 operations a year for patients from our region and suggested that for patients coming from outside the cost of the equipment (about £3500 for each operation) be met by the referring hospital while Guy's paid for the other major costs.

Conniving with cuts and training for management

RS: Another problem with doctor-managers might be that they are seen as conniving with cuts in the health service.

CC: Well, doctor-managers are responsible for public money and must make sure that it's used with maximum efficiency. Once you've done that you are much better able to argue for more resources. I've found that this is much more effective than going on television complaining about lack of resources, which is what I used to do four years ago.

AG: Your phrase "conniving with cuts" is a provocative way of saying that doctors would be playing a full part in management. If you become part of management then you must accept the difficult bits as well. But occasionally doctors may reach a point where they cannot support a series of cuts any further—and then they must think about resigning because your ultimate loyalty is to the patients and not to the budget. That's the advantage that the doctor has over the lay

administrator—his livelihood will not be removed by such an action.

CC: My view is that it's best not to think about resigning but rather to make a hell of a fuss. You are in a powerful position as a doctor.

RS: What about the difficulty that doctors are not trained for management? Do they need extra training to take on these responsibilities?

CC: I don't think that they need much. The important thing is to be interested and willing to learn. It is worth attending a few management courses and reading some books, but mostly you can learn from the people around you. The idea that you need a complicated training is a nonsense: you are not there to be an administrator. Indeed, I would resist any tendency in that direction because you may then cease to be a good doctor, fail to become a competent administrator, and be left stranded between the two.

AG: I don't think that there is any need for an elaborate training. Managing is something that doctors are doing all day long, and by and large they do it very well.

RS: But surely you can be a good doctor and a poor manager?

CC: I'm sure that's true—just as some people are good researchers and some are not.

RS: Let's turn now to the question of how quickly doctors might be encouraged to become managers all around the country.

AG: What I think we need is speedy but great debate on whether doctors should play a larger part in management. And if we can get doctors and the Department of Health to accept the concept then we can set up a small working party to work out the details.

RS: Do you think that doctors and the Department will accept the idea?

AG: I think that doctors will, but I'm less sure about the department. I think that there may be vested interests—the existing managers and administrators—who will oppose greater participation by doctors in management. But we must achieve a consensus and make it happen.

RS: So will doctors come to play a larger part in management?

AG: I think they will.

CC: I think so too. They will need to.

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