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Clinical directorates

Consultants' clinical independence needs to be preserved

In 1984 in response to a severe financial crisis Guy's Hospital decided to adopt the Johns Hopkins model of management and in so doing pioneered resource management in Britain. The medical staff, together with the nurses, took over the responsibility for managing the hospital. One of the key features of the Guy's management structure is that the running of the hospital is vested in a hospital management board, whose chairman is a consultant. In addition there are 16 clinical directorates, each headed by a lead clinician, who is a member of the board. Each director holds a budget, and to him or her is delegated responsibility for a wide range of activities including waiting lists and outpatient management.[1]

In the past year or two considerable pressure has been brought on all consultants to imitate this system of clinical directorates as a necessary step on the road to resource management—though the value of such management remains unproved.[2] In many cases the imitations have been a pale shadow of the Guy's experience. Boards of directors have evolved into groups of "lead clinicians" who are responsible to management for carrying out health authority policy—a far cry from the Guy's ideal of a group of doctors accepting corporate responsibility for the running of the hospital. The term "director" itself carries a certain status—"one who directs," or "a member of a governing body." But the term also carries the implication that the director himself is responsible to someone higher up the ladder. It places the consultant very firmly in a chain of management—with the implication that other, non-directorial consultants are tacitly drawn into the managerial chain at a lower level. Lay managers probably see the system as a means of exerting control over the hitherto unassailable autonomy of consultant decision making. Is that what the Guy's pioneers had in mind?

The consequences of abandoning consultant independence for a place in line management have very practical aspects. Where, for example, does a director stand in circumstances of severe underfunding? Lay managers will say that a director's duty is to agree a budget and to tailor his or her workload to match. But if a budget is inadequate a doctor's natural instinct may be to continue to treat as many patients as possible—and allow the money to run out, thus drawing attention to the underfunding. Such medical pressure has undoubtedly contributed to causing the government to make large injections of funds into the NHS in recent years. Are consultants now to be muzzled? A clinical director must walk a fine tightrope to be able to retain the right of independent criticism on the one hand but agree to work within a budget on the other. It is scarcely conceivable that industry would allow its middle and upper levels of management such unrestrained liberty.

The problems inherent in clinical directorates are not confined to the profession's relations with lay management, and many of these are discussed in the report published last week by the Institute of Health Service Management (p 492).[3] Interaction between the director and his or her fellow consultants is likely to prove troublesome. Anecdotes already abound of clinical directors who regard their title as giving them authority to influence their colleagues' clinical decisions—how else can they be responsible for their budgets? Fortunately, on this at least, the institute's report has given unequivocal guidance by emphasising that "the lead consultant does NOT become the manager of his or her consultant colleagues—the essence of clinical freedom of the individual practitioner remains intact."

How should doctors react when clinical directorates are proposed? The first questions that every consultant should ask are: "Precisely what is going to be different from the present system? What constraints are going to be applied (by lay managers or clinical colleagues) which will affect my clinical practice or way of working? Only when these questions are answered fully can a decision be taken. In many instances consultants are badly informed about what awaits them. They are fobbed off with the suggestion that directors will be, in effect, the same as chairmen of cogwheel divisions, with the management board becoming a type of medical executive committee: in other words, nothing will really change. Such an explanation should always raise the deepest suspicions. Why would managers go to such lengths (including that of paying the directors) in order to preserve the existing system?

The choice of director must always be acceptable to clinical colleagues and that person must be someone with whom management can work. This can be ensured by clinicians nominating suitable people for management to approve. To appoint a director who did not have the confidence of his or her consultant colleagues would be a recipe for disaster. A realistic assessment must be made of the work required, with arrangements for appropriate and acceptable remuneration and reduction in clinical workload during a consultant's term as director.

These are but a sample of the issues facing consultants who are being urged to form directorates. Professional bodies need to issue clear, concise, and comprehensive guidance to doctors if inappropriate and undesirable management systems are to be avoided and the clinical independence of consultants maintained.

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