

MANAGERIAL POWER AND MEDICAL INFLUENCE: CHANGING RELATIONSHIPS IN THE HEALTH SERVICE IN SCOTLAND

Allan Bruce and Sandra Hill

INTRODUCTION

The 1980s represented a decade in which there was a demonstrable shift in emphasis from structures which sought to preserve the autonomy of professional groups within the public sector, in favour of what is now generally described as the 'new public management' (Farnham and Horton 1993, Isaac-Henry et al 1993). The National Health Service was no exception, and in view of the preponderance of professionals operating within the NHS, there was, if anything, an even stronger motivation on the part of central government to strengthen the hand of management in the quest for efficiency, effectiveness and economy.

Given the widespread popularity of the NHS, however, a softly-softly approach had been taken with regard to the introduction of change. Managers, for the most part, seemed to avoid the prospect of confronting the medical profession head on (Harrison et al 1989). Indeed, it is only since the implementation of **Working for Patients** (DoH 1989) in 1991 that the pace of change appears to have quickened and deepened.

*Allan Bruce is a lecturer in the Department of Law and Public Administration, Glasgow Caledonian University, with a teaching and research interest in the funding and delivery of health care. Sandra Hill is a lecturer in the Department of Management, Glasgow Caledonian University, with a teaching and research interest in management development for health care. Glasgow Caledonian University, Cowcaddens Road, Glasgow, G4 0BA. A fuller discussion of the themes and issues contained in this article can be found in **Managing Doctors**, by Allan Bruce and Sandra Hill, Edinburgh University Press, £9.95, ISBN 0748607285.*

Managerial Power and Medical Influence

The effects of change in Scotland are beginning to become apparent as the reforms seek to strengthen their influence over the managerial agenda. Thus doctors, who in the past have managed to evade the prospect of detailed scrutiny, are now being encouraged to account for their actions and to take a more corporate view of their activities. Previously the medical profession had been insulated to some degree. Doctors have tended to seek the protection afforded by the principle of clinical autonomy and the relationship that they have enjoyed with the population who require health care.

There is some scope now for an introspective evaluation of relationships within the NHS as the nature of the managerial agenda brings with it the need to forge more meaningful partnerships between management and medicine. The crucial question, of course, is whether this can be realised within the context of recent reforms, or whether, as experience has demonstrated in the past, it will be difficult to achieve a meeting of minds. Doctors and managers, it seems, have been driven by different agendas which are often competing or conflicting, so that there is a sense in which clear water already divides the two. Managers now have the added challenge of attempting to gain the trust and cooperation of professionals within the context of a rapidly changing environment which appears to be at odds with some of the core values held by members of the medical profession.

In essence, the main themes and issues addressed within the context of this research programme is the continued emphasis that has been placed upon the management of the NHS by central government. The context in which this managerial focus has been promoted has changed. The split between purchaser and provider has been accompanied by increased fragmentation. Large bureaucracies have given way to smaller provider units which are now expected to compete for contracts. Some of these changes are specific to the NHS but they are also part of a more general cultural and political shift that has been experienced in the public sector.

The impact which these changes have had upon professional groups are important. Fears have been expressed that there has been an erosion of professional status and autonomy. What follows, therefore is an attempt to examine the nature of power and influence within the health service in Scotland as managers attempt to implement a central government agenda which is overwhelmingly political in nature.

METHODS AND APPROACHES

The empirical material upon which this analysis is based is drawn from a total of 63 interviews with senior managers, medical directors, clinical directors and consultants. Interviewees were identified from eight acute hospital units in the West of Scotland, and interviews took place between July and December 1993. Three geographical locations were represented where Area Health Boards operated as the major purchaser - three hospitals from each of two areas and two hospitals from a third.

The hospitals selected represented a varied cross section and, in terms of their size, ranged from a 450 bedded unit with an annual budget of around £33 million to an 800 bedded unit with an annual budget of £110 million. Staffing levels ranged from around 1500 to 5000. The sample also contained one teaching hospital. At the time the interview programme was being conducted, four of the Hospitals in the sample had become Self Governing Trusts in April 1993. The remainder were in the process of applying for Trust status and in all cases their applications had been issued for public consultation. One area contained two Trusts and one Directly Managed Unit, another area yielded one Trust and two Directly Managed Units, and a third area provided one Trust and one Directly Managed Unit.

Within each hospital, interviews were conducted in all cases with the Chief Executive or Unit General Manager, the Director of Finance, and the Medical Director. With reference to the latter, one hospital did not have a medical director and, in others, the nature of his roles and responsibilities often differed, as did the job title itself. At an operational level, interviews were conducted with clinical directors in general medicine, general surgery and radiology or diagnostic services. Each of these directorates were common to all hospitals, though in practice were seldom directly comparable across the sample selected.

The size of directorates in terms of beds varied between 110 and 300 and annual budgets ranged from £1.5 to £16 million. Some measure of caution, however, must be exercised when quoting annual budgets, since directorates were at various stages of evolution. Some hospitals had devolved much more budgetary responsibility to directorates than others, so that there was often no obvious relationship between operational budgets and size of directorates. The number of directorates varied between hospitals from six in the smallest unit to around 14 in one of the largest, and the length of time that clinical directors had been operational varied too. In two units a directorate structure

Managerial Power and Medical Influence

had been in operation since around October 1991, two units had appointed clinical directors in 1992, and four units had appointed clinical directors in 1993.

The interview programme also included a round of interviews with consultants who were not themselves directly involved in managing a directorate. One consultant was selected from each of the directorates with the intention of developing ideas about the impact of change upon relationships between peers. Only one clinical director refused to be interviewed, giving as his reason a lack of time, and another clinical director could not be interviewed because of the absence of a mutually convenient time. No consultants were interviewed from these directorates, and the researchers were unable to identify mutually convenient times for another four consultants.

Summary of Interview Sample

<i>Participants</i>	<i>Totals</i>
Chief Executive or Unit General Manager	8
Director of Finance	8
Medical Directors	7
Clinical Directors (Medical)	7
Consultants (Medical)	5
Clinical Directors (Surgery)	7
Consultants (Surgery)	5
Clinical Directors (Radiology)	8
Consultants (Radiology)	8
Total	63

Interviews were semi-structured in their nature with a view to encouraging a productive dialogue with the interviewee. This allowed an open-ended approach in which respondents were encouraged to develop issues pertinent to their own individual experiences. A principal focus of the research, therefore, was to obtain a feel for the changes that were being promoted as

Scottish Affairs

opposed to generating quantitative data for analysis. Consequently, the research findings reported here recognise that there is a considerable amount of diversity within a managerial environment which is continuing to evolve. Where possible we have attempted to summarise general trends and views whilst at the same time recognising that opinions will continue to shift in line with managerial change.

PRESSURE FOR REFORM

In spite of ongoing efforts to realise the aspirations contained in the Griffiths Report (DHSS 1983) to involve doctors in management, it is not self evident that this objective had been fully realised before the NHS was subjected to yet a further round of reforms in 1990 (Harrison et al 1992). Thus, while some doctors and managers may have recognised that advantages were to be derived from developing workable agreements and from building more productive partnerships, there was also a sense in which some analysts felt that fundamental difficulties still had to be resolved (Scrivens 1988). There was, it seems, still something of a chasm between the aspirations of both management and medicine. Evidence of this divide was manifest in terms of cultural differences and a tradition on the part of the medical profession of being accountable largely to itself.

With the publication of the White Paper - **Working for Patients** - in 1989, the NHS was exposed to a number of wide ranging reforms. The purchaser-provider split was introduced and there started the 'inexorable metamorphosis of NHS management units into Trust status [which was] a powerful reaffirmation of the Government's continuing search for an effective vehicle for locally based management and a shortening of the administrative tail' (Dickens 1993 p.ix). This continuing quest for efficiency, effectiveness and economy has brought with it the possibility that managers will be seeking to scrutinise the activities of the medical profession. After all, prescribing and ordering treatment for patients means that the medical profession is, and will continue to be, a major influence upon the allocation of scarce resources.

With early attempts to bring doctors on board having fallen upon stony ground, in many cases it was not until the implications of the 1990 reforms began to work through the system that the medical profession began to display an interest in the process of change at a local level. The decision to express an interest in Trust status did not in all cases mean that doctors were supportive of management in their application. Nevertheless, as the internal

Managerial Power and Medical Influence

market developed and more concrete relationships were established between purchasers and providers, many doctors began to realise that they needed to participate in the management of services if they were to retain their influential status within the NHS.

In cases where the possible rationalisation of service provision was discussed by purchasers, it became evident that competition for the provision of some services could well turn out to be very keen. The sites covered in this study are in relatively close proximity to each other, so that each has been influenced to some degree by the operation of the internal market and an increasing number of General Practitioners opting for fund-holding status. The need, therefore, to retain a competitive edge in bidding for contracts, which would ultimately facilitate the maintenance and development of services, was a major factor in decisions to apply for Trust status, and in encouraging doctors to become more closely involved in the managerial agenda.

On this basis, therefore, while the need to encourage doctors to become more closely involved in managing resources is hardly innovative, the separation of responsibility for purchasing health care from its provision has added urgency to the need for participation. It has also enhanced the speed at which it has had to occur. The notion that managers have seen their interests as being to support and sustain the interests of doctors entered a new arena of attempting to encourage doctors to change sides and support and sustain the managerial agenda (Hunter 1992).

What this study attempts to demonstrate is that both doctors and managers are, to some extent, agreed that there is a need for doctors to be involved in management. In practice, however, there are observable differences in the nature and the extent to which cooperative arrangements are perceived. A large number of clinical directors and consultants acknowledged that external influences such as competition, contractual agreements, trust status and a greater interest in financial accountability were influential factors in forging new working relationships between management and medicine. However, the single most important factor was often thought to be the personal influence and disposition of the Chief Executive or Unit General Manager. If relationships were healthy and cooperative before the reforms began to take effect, then the likelihood of achieving a smooth transition to a cooperative clinical directorate structure was enhanced.

Moreover, in one case there was evidence to suggest that the relationship between doctors and managers had been retarded specifically as a result of

Scottish Affairs

the disposition of the Unit General Manager. Yet, with the subsequent appointment of a new and widely respected Manager in the run up to an application being made for Trust status, there were clear indications that potentially problematic relationships could be turned around.

Bringing doctors into management highlighted many other issues for managers, not least the need to ensure adequate support and information to allow doctors to manage resources. Information systems available were on the whole inadequate for the new and additional demands being placed upon hospitals. As competitive forces become more influential and as more responsibilities are devolved to specialties, flaws in the systems are more apparent. This deficiency has an obvious impact on the ability to delegate decision making to an operational level.

As new structures to enable doctors to become involved in management are discussed, other methods of support still need to be established. Consultants, being very highly skilled and costly employees, need to make the best use of their time. Against a backdrop of government pressure to reduce waiting times, waiting lists and other targets set by initiatives such as the Patients Charter (DoH 1991), new challenges have been identified. For example, managers are now faced with the very real prospect of reducing the clinical input of some of the most senior consultants within their units, specifically to allow them to participate in management.

DOCTORS INTO MANAGEMENT: THE MEDICAL DIRECTOR

Whilst the title of medical director has been around since the implementation of general management in the mid 1980s, it is only comparatively recently that this post has been the focus of attention. The reason for this is that a Self Governing Trust has a statutory requirement to appoint a medical director as an executive member of the board.

The role of the medical director is one which invited a wide range of responses, not least the debate about whether the post should be full-time or part-time. Of the eight sites studied, only two had full-time medical directors. Job titles also varied, with only three sites having appointed what was described as a medical director. Other titles were medical manager, clinical services manager, director of medical services and a medical adviser. Roles and responsibilities also varied according to different interpretations of job

Managerial Power and Medical Influence

descriptions. Some medical directors were clearly intended to be part of the managerial hierarchy, while others existed largely in an advisory capacity.

In a few of the sites, Chief Executives and Unit General Managers indicated that the role of medical director embraced wider responsibilities than were expressed by the post holders, clinical directors and consultants. Some medical directors had a very clear vision of their role in terms of being the driving force behind clinical directors as well as influencing corporate policy from a medical perspective, whilst others were less sure of their future role. Doctors tended to believe that a medical director's loyalty should be to the profession first and to provide strong medical representation on a Trust Board. They believed the medical director to be one of the most important positions to be developed to meet the current agenda of change. One medical director, however, saw his role as 'more of bringing the externally influenced agenda to the clinical group than bringing clinical issues to management'. He indicated that the challenge lay in enticing doctors to participate. Some clinical directors and consultants were also more realistic about this possible future, believing that the medical director would have one foot firmly placed in the managerial camp.

The need to have clinical credibility with medical staff would appear to be uppermost in everyone's minds. Consultants in particular were concerned that clinical credibility would be lost if a substantial clinical commitment was not maintained by the medical director. There was overwhelming agreement that the medical director was the link between managers and the medical needs of the hospital. It was suggested that a doctor could better represent the best interests of the patients. Doctors did not appear to have considered that managers may also place patients' interests high on their agenda, believing them instead to be driven primarily by the implementation of government policy and financial constraints.

NEEDS AND OBJECTIVES OF CLINICAL DIRECTORATES

Doctors have traditionally enjoyed a unique position in the NHS, influencing the policy agenda to the extent that the NHS has largely reflected the priorities that have been imposed upon it by the medical profession (Klein 1989). The NHS it seems had suffered from what might be described as 'producer capture', wherein it had become difficult to achieve change. One government minister in the mid-eighties felt that getting the NHS to change direction was like turning an aircraft carrier, though, unlike the NHS, an

Scottish Affairs

aircraft carrier at least had the benefit of a sophisticated set of controls (Griffiths 1991). Formally involving doctors in the managerial process as a means of achieving change was tackled in all sites by introducing a clinical directorate structure.

Senior managers indicated that they wanted doctors to have more ownership and responsibility of the services they provided. Some clinical directors and consultants believed that, by giving doctors ownership of services, managers were also making the clinicians accountable for the use of resources. This view was shared by managers, and, as one Chief Executive put it, 'doctors in management is a means of exerting control'. Nevertheless, the need to gain a shared commitment from staff was cited by both groups as a key force in achieving success for the unit, especially when making an application for Trust status.

The clinical directorate structure involved devolution of responsibility, accountability and management within a defined group of services. The extent to which devolution has occurred varied between sites, usually according to the time that directorates had been established and the level of participation by medical staff. The extent to which participation could be achieved was often related to the disposition of medical staff to the 1990 reforms and of their perception of the managerial agenda. It was clear that some directorates contained a number of individuals who were lukewarm about the reforms or were openly hostile. There was a tendency in these instances to see behaviour which was largely defensive in character.

When selecting a clinical director, most managers asked for nominations from the appropriate consultant group. However, if the nominee was seen as a 'puppet' appointment, then managers would lobby more appropriate consultants to apply for the position. In any case, as one Chief Executive observed, 'when consultants realise that important issues are being dealt with at these meetings, then they will be increasingly less willing to tolerate a situation in which their clinical director is there merely to make up the numbers'.

This first generation of clinical directors, however, are something of a mixed bag with only a small minority of clinical directors exhibiting strong managerial skills. There is a middle order, who by their own admission lack experience but are able and willing to strengthen their role. Bringing up the rear, while there was little evidence to suggest that there had been a preponderance of 'puppet appointments', some directorates appeared to be

Managerial Power and Medical Influence

treading water. It was clear, for example, that in some directorates younger consultants were preparing themselves to become clinical directors of the future. The next generation of clinical directors, therefore, may well be more willing, able and powerful, exhibiting more of a desire to take control.

The motives for consultants becoming clinical directors fell into two of the three categories of doctor-manager described by Perey (1984). On the one hand there was the 'accidental part time manager' who is regarded as an expert in their clinical field. These individuals are held in high regard by their colleagues and seen as the natural leader for the directorate. Then there was the 'management prone specialist', most evident in the non-bed-holding specialties such as radiology and diagnostics. None of the clinical directors and indeed only one of the medical directors could be described as a 'career manager', having chosen at a relatively early stage in his career to take a full-time managerial post.

Personal motives for becoming a clinical director were varied, ranging from a desire to influence service provision and become involved in the management process, to stopping others from getting the post. Money was not acknowledged as a motive by many, although one clinical director indicated that 'whilst money is not a motive, it is unlikely that many doctors would do the job if there was no financial reward'. The possibility of management activities being relevant to Merit Awards had also raised the interest of many of the clinical directors and consultants. Other motives suggested included a desire for power, a new challenge, a career opportunity, protection of individual specialties and preparation for retirement - a physically less demanding job.

The roles and responsibilities of clinical directors varied between sites depending on the length of time the directorate had been in operation and, to some degree, upon the disposition of clinical directors. Some clinical directors saw their role as co-ordinating services whilst others saw themselves as being managerially responsible for the directorate. Where agreement on the role of clinical directors had not been reached between doctors and managers, a compromise had been reached, and clinical co-ordinators were appointed with less of a direct management role. This was the case particularly in terms of staff management and budgetary responsibilities.

In terms of skills required to do the job, there was overall agreement that the most important skills were the 'soft skills', communication, leadership, team

Scottish Affairs

building, influencing and negotiation skills. Negotiation skills were seen to be crucial as clinical directors became involved in the contract-setting process with purchasers. Some clinical directors, however, were concerned that to date they had had little involvement with purchasers, and, as one clinical director observed, 'how can we be held responsible for meeting contracts if we do not play a part in negotiating them?' Many thought that these skills could not be learned to any great extent but that they were inherent.

'Hard skills' such as financial management and business planning techniques were seen almost universally to be useful and acquired more easily than the interpersonal skills. Above all, clinical directors needed to have the respect and trust of their peers and the commitment to working beyond the one session that is, in most cases, allocated to them for their managerial duties.

A range of training methods have been employed to enable clinical directors to carry out their role, with varying degrees of success. It would appear that clinical directors are less than happy with 'whiz kid' management consultants who do not demonstrate an in-depth knowledge of the workings and culture of the NHS. Most favoured the 'away-day' approach which dealt with in-house issues, even if facilitation was conducted by external bodies. The MBA for doctors would also appear to be a popular choice for some clinicians preparing themselves for management. In some cases even junior doctors have been looking to the future and are currently undertaking MBA programmes.

Consultants indicated that clinical directors were beginning to develop their own styles of management. Research findings tend to confirm this and indicate that these management styles fall into four broad categories. In the first instance there is the 'diplomat', whose principal objective is to maintain harmonious relationships with both management and colleagues. The 'diplomat' will ensure that relevant information for decision making is passed between the two groups, though this has invited some criticism from colleagues that there has been a substantial increase in the amount of paperwork. 'Diplomats', however, see themselves essentially as buffers between management and the coal face and decision making within the specialty remains, for the most part, a collective activity.

Then there is the 'fixer', who takes a more active role in problem solving within the directorate. The main thrust of this role is to ensure that services are run efficiently as well as encouraging the participation of colleagues in

Managerial Power and Medical Influence

the decision-making process. A feature of the 'fixer', however, is that he or she will often be dealing with relatively minor issues and will be dealing with problems as they occur. The 'fixer' responds to issues that are brought to them by management as well as dealing with demands that are initiated by their colleagues. Both the 'fixer' and the 'diplomat' tend to relate well to colleagues, but there is little or no evidence to suggest that they are as yet able or willing to exert a more substantial degree of managerial influence over their peers.

The 'careerist' on the other hand displays stronger managerial interests, is more proactive and is preparing the way for a more developed role within medical management. The challenge for individuals who fall into this category in the future is how to tread a fine line between the desire to influence colleagues - maintain healthy working relationships - and, at the same time, developing the specialty within the context of a rapidly changing environment.

Finally there is the 'puppet' who adopts a laissez-faire approach and would seem to offer little in the way of a proactive management style. Within the sample group most of the clinical directors fell into the 'fixer' and 'diplomat' categories. There was some evidence that as clinical directors became more confident and skilled in their role, their management style changed from, for example, 'diplomat' to 'fixer'. Similarly, if managerial pressure upon clinical directors becomes more acute, there is the prospect of 'fixers' becoming more career-orientated managers with a more proactive style.

There were reservations expressed by both doctors and managers about the introduction of clinical directorates. Well over half of the doctors interviewed, and indeed one Chief Executive, believed that new structures had been introduced simply to satisfy the Government's wishes, regardless of the best interests of the consultant body. In terms of the impact of change, however, there were two broad schools of thought. First, there were a number of doctors who did not think that attempts to bring doctors into management would make any significant difference to the way they carried out their day to day work in the hospital. Conversely, others acknowledged that the changes in the structure had given doctors a real opportunity to influence how services should be delivered and to have an impact on strategic decision-making within the hospital. There was overwhelming agreement that the clinical director's job was not an easy one, especially as they tried to juggle clinical and management commitments alongside

Scottish Affairs

potential conflicts of interest. Time constraints were cited as by far the most restricting factor that clinical directors found in carrying out their role.

The move to management has been more problematic for some consultants than others. The level of support offered to clinical directors varied between sites and, indeed, within sites. Many clinical directors expressed concern about the level of additional work that their managerial role entailed and the burden this often placed upon their colleagues. All but a few recognised that they were relatively poorly equipped in terms of skills, experience and managerial support for important elements of the job. Whilst managers recognised these difficulties, they were also faced with juggling the competing and conflicting demands upon their time.

Suffice to say that it is all too common for the urgency of external pressures to take precedence over demands generated from within. Most managers are aware that even if adequate support exists for the clinical director in terms of business and financial support, there is still a pressing need to provide skills training and personal development to clinical directors.

RELATIONSHIPS BETWEEN CLINICAL DIRECTORS AND SENIOR MANAGERS

Relationships between consultants and senior managers have often been at best lukewarm and, at worst, characterised by overt conflict. Hunter (1992), for example, has pointed out that the nature of medicine is such that there is a preference for organisational forms that are collegial in nature. This is at odds with the traditional managerial orientation in which emphasis is placed upon hierarchy and on clear roles and responsibilities at different levels. This difference in culture was observed by one consultant who indicated that 'managers who are used to a hierarchical structure will rarely follow the independent approach that seems to be the hallmark of the medical profession and they will invariably work within parameters laid down by policy'.

This particular view, it must be said, fails to recognise more recent developments where management have been endeavouring to introduce structures which are more akin to matrix models. Nevertheless, there was still a gulf between management and medicine in a cultural sense. However, increased fiscal pressures and continued managerial reform may now provide an environment in which more attention must be paid to compromise and to

Managerial Power and Medical Influence

the necessity to bring about workable agreements. As one medical director put it, 'to bring doctors and managers together seems to assume objective reality and this...creates [unproductive] tensions'. On a more positive note, however, he advocated the need for clinical directors to promote the interests of their directorates, so that relationships between management and medicine might instead be characterised by 'a creative tension'.

The changing nature of relationships between management and medicine was acknowledged by a majority of those who were interviewed. All managers interviewed believed that relationships had changed since the 1990 reforms, with a small minority laying claim to a tradition of involving consultants in strategic and operational planning issues. Only a minority of consultants were unaware of any changes, and, in their defence, would often indicate that they had always been rather remote from management. More recently, there has been a tendency for clinical directors to absorb any managerial flack. Finding clinical directors who had failed to observe change was invariably much more difficult though there were a few isolated examples, usually in areas where fiscal pressures were not as yet terribly acute, or in directorates that had only recently been established.

In terms of the driving forces behind the imperative for change, most respondents had explicitly recognised the influence of the post-1990 reforms. With the attainment of Trust status, senior management had assumed more responsibility for the development of strategic objectives, creating more of a 'hands on' approach which had an impact upon relationships. Even for hospitals with an application for Trust status in the pipeline, important issues had to be addressed. One manager for example had indicated that he was 'having to knock the Hospital into shape in order to compete with other providers'.

More generally, management tends to be much more visible now than in the past, taking a much more proactive role, or as one clinical director suggested, an 'over-active' role. Nevertheless, management has been transformed over the last decade or so, and there is a recognition amongst clinical directors that this new breed of managers are people who make things happen, rather than administrators who merely get things done. The number of managers has also increased, though there was some degree of pessimism on the part of some clinical directors about the quality of individuals swelling more junior managerial posts. This may in part be due to status, where one manager suggested that 'consultants can tear strips off junior managers but are much more moderate in their dealings with senior managers'.

Scottish Affairs

For the most part, however, managerial strategies were characterised by a softly-softly approach, where senior managers were all too aware of the need to gain the trust and cooperation of clinical directors. On a number of occasions senior managers had made it clear that the medical profession is often largely immune to direct action from non-medical personnel, indicating that managing doctors is very much 'like herding cats'. Managers are, nevertheless, increasingly more prone to ask searching questions of doctors and are gradually encouraging scrutiny. A cornerstone, however, of any future strategy is likely to depend upon the disposition of the medical director, who as a doctor would be better placed to take the managerial agenda to clinical directorates.

This is not to say, however, that managers have been willing and able to challenge the medical profession in terms of their clinical autonomy. Overwhelmingly both managers and doctors have indicated that managers are neither able nor willing to make incursions into the sphere of individual professional judgement. There has been a popular mythology surrounding the nature of clinical autonomy which many doctors have used to advantage in the past. More realistically, however, clinical autonomy is not all-embracing, covering every aspect of medical practice. Clinical autonomy is a concept that a substantial number of respondents recognised as being necessarily limited, specifically in terms of the resources that are available. Managerial initiatives are for the time being peripheral to individual professional judgement, and are concerned with more general issues relating to resources such as bed use, the drugs budget, use of theatre time, levels of activity, and waiting lists.

Where the medical profession may increasingly become frustrated is in the realisation that it is becoming more difficult to identify new developments and expect them to be funded. In the past, developments could be initiated using 'soft money', often money that was intended for research. Having established the service, momentum could then carry it along. Directorates are now being asked to justify new developments in terms of both capital and revenue expenditure, and to provide management with proposals that are more tangible. These proposals can then be discussed with purchasers in terms of future demand and viability. This approach, as one clinical director indicated, has advantages and disadvantages. 'In terms of advantages, there is not the same opportunity for duff developments to go ahead. These developments can quite rapidly be stifled. On the down side it may have the effect of stifling medical initiative'. On more than one occasion, doctors

Managerial Power and Medical Influence

warned against the dangers of a recipe book approach to medicine. On these occasions, they were clear in terms of the need for medical judgement.

RELATIONSHIPS BETWEEN CLINICAL DIRECTORS AND THEIR PEERS

In terms of relationships with their peers, evidence for the time being suggests that the establishment of a directorate structure and the appointment of clinical directors has not resulted in significant change. Evidence points to relationships that remain largely collegial with little to suggest that there have to date been any serious incursions by clinical directors into what are regarded as professional decisions. Strategies for influencing colleagues are based largely upon persuasion and leading by example. In all cases, however, directorates are at an early stage in their development. There is, for the time being, a tendency for clinical directors to focus upon relatively minor issues; there was also a recognition amongst some consultants that this position could be transitory.

All consultants exhibited a considerable amount of sympathy for the position of clinical directors. They were aware that these individuals had the unenviable task of dealing with corporate issues and, at the same time, of dealing with potentially conflicting demands emanating from the directorate. The difficulties associated with these conflicting pressures were clearly recognised by both clinical directors and consultants alike. Also there was the very real pressures upon the time that clinical directors were able to allocate to their managerial responsibilities. Clinical directors were not just appointed for their potential to inject a measure of managerial acumen into their directorates; it was clear that, for many appointments, credibility and respect from colleagues was an important consideration. For this reason, clinical directors have been reluctant to reduce their clinical load, feeling that, if they did, credibility and respect may be diminished.

Clinical directors were keenly aware that the prospect of influencing their colleagues was potentially the most demanding aspect of the job, but, as one clinical director put it, 'you have responsibility without any real power'. Clinical directors must inevitably seek the cooperation and confidence of their colleagues, but it may be difficult to achieve this and manage the directorate - in other words, of meeting the needs and demands articulated by colleagues and meeting organisational objectives. In terms of establishing a policy direction, exhortation, persuasion and leading by example

Scottish Affairs

predominated, with clinical directors indicating that they would have to try to take colleagues with them.

In developing a policy direction for the directorate, it was clear that clinical directors were only just beginning to feel their way. Some had taken their lead from the directorate's business plan, where it existed, and had made tentative moves to encourage colleagues to do the same. Others had identified strategies such as improving the operational efficiency and strengthening the directorate's position to submit bids for additional resources. A minority of clinical directors were, for the time being, intent upon maintaining the status quo. Yet even here, there was at least a sense in which colleagues regarded the clinical director as more of a focal point than the chair of the division.

Most consultants readily conceded that the clinical director's role was not merely a refashioned chair of division, and that the roles and responsibilities of clinical directors have a broader focus, bringing with it the potential for increased managerial responsibility. In many instances, the clinical director was indeed also chair of the division, and in this sense usually enjoyed the support of colleagues. In cases, however, where the clinical director and chair of division are not the same person, there may need to be some compromise between roles which are in a theoretical sense managerial and roles which are representative in character.

Diskin et al (1990) have indicated that some clinical directors felt that medical advisory structures may need to be revised because of the potential for confusion, while others felt it would continue to be a useful forum for consultants to put forward their views. A great deal will depend upon the way in which the role of clinical director is developed. Thus, while recognising that clinical directors will be influenced by the managerial agenda, consultants remain hopeful that clinical directors will be able to fight for their own corner and seek to represent the views of consultants in the policy-making process. After all, clinical directors are doctors first and managers second; failure to recognise a representative role would run the risk of isolating their peers.

CONCLUSIONS

Evidence would seem to suggest that there are very real inducements (whether positive or negative) for change, but it is not self evident that the

Managerial Power and Medical Influence

potential that exists has been fully realised. Thus, while there are several very real pressures, there are also several countervailing tendencies that have had the effect of acting as constraints.

There is the very important question of time, or rather the lack of it. One thing that was clearly in evidence is that newly appointed clinical directors have had an increasing number of demands placed upon their time, which must in itself compromise the prospect of securing lasting and meaningful change. The issues surrounding this question of time were viewed from different perspectives, which was in itself indicative of problems associated with both management and medicine operating on the basis of separate agendas. Managers for the most part were appreciative of the demands that the managerial role placed upon clinical directors, but, by the same token, clinical directors felt that more support could and should be offered. Competing demands upon managerial time may in part explain the neglect of this issue, since the development of clinical directorates was only part of an arduous managerial agenda.

There is, nevertheless, a fairly clear logic for the continued development of the clinical director's role if it is to be regarded as a serious contribution to the management of health care in the future. In order to develop that role, resources must be devoted to preparing doctors for the managerial responsibilities that they are being asked to take. The same would be true for the medical director, since there is currently no obvious career path for this role. There were indications throughout the study to indicate that younger consultants and, in some cases, registrars and senior registrars were preparing themselves for the future in terms of doctors as managers.

Within the sample group examined by this study, although there were indications to suggest that some doctors had warmed to the challenge offered by attracting doctors into management, this trend was not universal. Many doctors remained sceptical, and this must represent a challenge for management. Moreover, success cannot merely be defined as bringing doctors into management, but a significant challenge remains to get clinical directors to take a corporate approach in the management of health care. There is a possibility that the devolution of responsibility to directorates will be used as a means of promoting vested interests and of maintaining the status quo. There are also questions to be asked about whether managers are able to devolve responsibility to doctors with confidence and whether it is feasible to expect doctors as managers to develop policy initiatives and see them through.

Scottish Affairs

The research findings we have discussed have had a Scottish focus. There is a sense in which the Scottish reforms differ from the situation south of the border, where experience has indicated that a tougher stance has been taken by both managers and politicians. If, however, the pressure being placed upon the health service in Scotland by the internal market and its accompanying paraphernalia is intensified to the same degree as in England, then the friction between doctors and managers may well intensify. With increased pressure upon doctors to accept managerial responsibility and to expose clinical activities to increased scrutiny, there might well be an increased reluctance on the part of doctors to comply. Pressure points are already evident in other areas of the UK, resulting in increased stress for both groups with little or no evidence of tangible benefit to patient care.

REFERENCES

- Department of Health (1989). **Working for Patients**, Cm 555, London: HMSO.
- Department of Health (1991). **The Patients Charter**, London: HMSO.
- Department of Health and Social Security (1983). **NHS Management Inquiry** (Chairman: Roy Griffiths), London: DHSS.
- Dickens, S. (1993). 'Foreword', in Spurgeon, P. (ed), **The New Face of the NHS**, London: Longman.
- Dixen, S. Dixon, M. Halpern, S. and Shocket, G. (1990). **Models of Clinical Management**, London: Institute of Health Services Management.
- Farnham, D. and Horton, S. (eds) (1993). **Managing the New Public Services**, London: MacMillan.
- Griffiths, R., (1991). **7 Years of Progress - General Management in the NHS**, Management Lectures No 3, London: Audit Commission.
- Harrison, S. Hunter, D. J. Marnoch, G. and Pollitt, C. (1989). 'General Management and Medical Autonomy in the National Health Service', **Health Services Management Research**, Vol 2, No 3, 38-46.
- Harrison, S. Hunter, D. J. Marnoch, G. and Pollitt, C. (1992). **Just Managing: Power and Culture in the National Health Service**, London: MacMillan.
- Hunter, D. J. (1992). 'Doctors as Managers: Poachers Turned Gamekeepers', **Social Science and Medicine**, Vol 35, No 4, 557-566.
- Isaac-Henry, K. Painter, C. and Barnes, C. (1993). **Management in the Public Sector: Challenge and Change**, London: Chapman and Hall.

Managerial Power and Medical Influence

Klein, R. (1989). **The Politics of The National Health Service**. London: Longman, second edition.

Perey, B. J. (1984). 'The Role of the Physician Manager', **Health Management Forum**, 48-55.

Scrivens, E., (1988). 'Doctors and Managers: Never the Twain Shall Meet', **British Medical Journal**, Vol 296, 25th June, 1754-1755.

February 1995