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Medicine, management, and modernisation: a "danse macabre"?

Pieter Degeling, Sharyn Maxwell, John Kennedy, Barbara Coyle

To break their destructive antagonism over issues of health service modernisation, doctors and managers should engage more directly with nursing and allied health professionals when responding to reform initiatives

Edwards and Marshall have recently called for constructive dialogue to replace the mutual suspicion between doctors and managers.[1] They suggest that the recent tensions over the negotiation of the new UK consultant contract should be seen as part of a "deeper problem [with] a long history." They propose that doctors' and managers' very different approaches to issues such as accountability, use of guidelines, and finance are the result of each discipline's training, beliefs, and experiences. Finally, they suggest that, left unresolved, these differences have the potential to threaten individual institutions and perhaps even the future of the NHS.

In this article we offer a brief analysis of the wider nature and the essential elements of the reforms being sought by governments. We offer some cross-national evidence to support the proposition that understanding different professional cultures is crucial for understanding each profession's response to the reforms. We conclude by drawing on that evidence to offer some ways forward.

Orientations of reform

Reforming how clinical work is organised, performed, and monitored has been at or near the top of the policy agenda in most industrial societies for the past 25 years. The reasons for this are:

- The growing cost of health care, leading to questions about the resource efficiency of existing modes of service delivery
- Doubts about the appropriateness and value of existing patterns of clinical work organisation

Summary points

Calls to modernise health services require health professionals to accept that all clinical decisions have resource dimensions, recognise the need to balance clinical autonomy with transparent accountability, support the systemisation of clinical work, and subscribe to the power sharing implications of team based approaches to clinical work

There are consistent and marked differences in how medical, nursing, and managerial staff across countries evaluate individual aspects of such a reform programme

Policy authorities' efforts to overcome resistance to reforms by widening the scope and reach of "top-down" performance management and regulation are self defeating

What is required is more support for clinicians and others (including nurse managers) to pursue modernised clinical work practices

Re-establishing "responsible autonomy" as the primary organising principle of clinical work will empower health professionals to strike a balance between the clinical and resource dimensions of care and between clinical autonomy and transparent accountability

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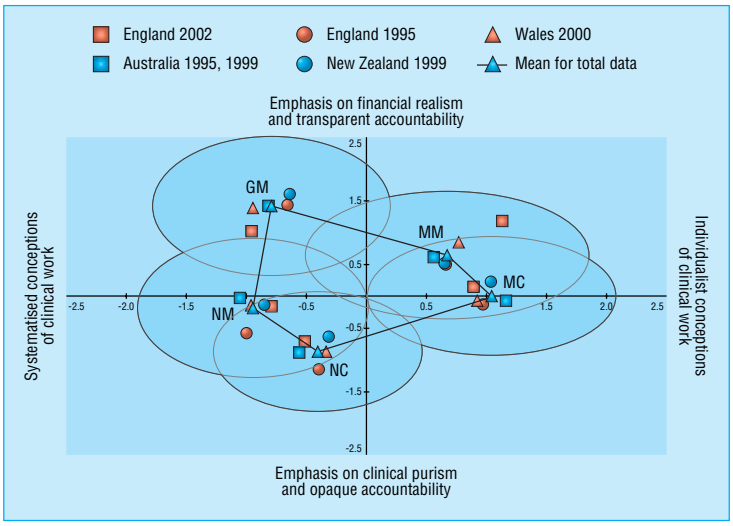

Profile of healthcare professionals' conceptions of clinical work. MC=medical clinicians, MM=medical managers, GM=general managers, NM=nurse managers, NC=nurse clinicians. Ovoids represent 1 standard deviation from mean (69% of each professional group fall within that area)

- Worries about the medical profession's capacity to ensure the accountability of its members.[2 3]

These issues are best tackled at the level at which clinical work is performed. When clinicians make decisions about what constitutes best practice, they are also making decisions about how care should be organised. When applying those best practice decisions in their encounters with patients, clinicians are also allocating and spending the health budget. Reform initiatives to address these concerns, however, are characterised by their dependence on "top-down" bureaucratic mechanisms external to individual clinical settings, such as market mechanisms and moral persuasion.[4 5]

Examples of these top-down approaches in Britain include capped hospital budgets, tightened spending controls, and an increasing range of performance indicators. Competitive arrangements such as purchaser-provider splits and requirements for provider diversity represent efforts to introduce the discipline of the "market" into health care. Shifting the balance of power towards primary care trusts and the introduction of tariffs based on case mix for service commissioning for these trusts are recent examples of this approach. As with the earlier "internal market," the policy hope is that these arrangements will stimulate hospital managers to attend more closely to efficiency and quality in service delivery.[6 7]

Moral persuasion initiatives have been directed at increasing clinician involvement in clinical audit, quality improvement, and evidence based clinical practice (despite many of these initiatives having emanated from within medicine itself).[8] The highly publicised failures of (medical) self regulation in England such as the Bristol and Shipman cases, however, has led policy authorities over the past five years to adopt a more regulatory approach.

For example, the National Institute for Clinical Excellence and national collaboratives now set standards for care, which the Commission for Health Improvement uses to assess providers' performance. These are complemented by an extensive national performance framework[9] and a national patient and user survey. Policy authorities intend that this clinical improvement agenda will be given local effect via clinical governance mechanisms that make trust boards directly responsible for quality assurance, clinical audit, risk reduction, and related clinical development programmes among staff.[10]

Healthcare managers, however, need the active participation of healthcare clinicians, especially doctors, to implement these policy initiatives at the level that clinical work is done.[11] Whether that active participation is forthcoming depends in part on how the various professions interpret the policy initiatives and on the conflicts of priority that exist even among holders of common objectives.[12] These, in turn, are dependent on how the various professions conceive of clinical work.

Clinicians' perceptions of reform

Stripped down to its essential elements, the "modernisation agenda" described above calls on doctors, nurses, allied health workers, and managers in acute, primary, and community settings to:

- Accept the proposition that all clinical decisions have resource dimensions
- Recognise the need to balance clinical autonomy with transparent accountability
- Support the systemisation of clinical work
- Subscribe to the power sharing implications of team based approaches to clinical work.

Evidence about how healthcare professionals view these issues was obtained from a survey of 3065 medical clinicians, medical managers, general managers, nurse managers, and nurse clinicians working in 26 hospitals in England, Wales, Australia, and New Zealand.[13–16] The survey asked questions about health professionals' attitudes towards:

- Key healthcare issues
- Strategies for dealing with hospital resource issues
- Interconnections between clinical and resource dimensions of care
- The causes of variation in clinical practice
- Who should be involved in setting clinical standards
- The forms of knowledge on which clinical standards should be based
- How clinical units should be based
- The accountability and autonomy of clinicians
- The organisation of their trust.

The results strongly suggest that medical, nursing, and managerial staff have distinct, profession based conceptions of clinical work. The data show that these differences occur on four dimensions, two of which account for 93% of the variation in the data (figure). The figure shows highly significant differences ($P < 0.001$) between professional groups in terms of individualist versus systematised conceptions of clinical work and in terms of conceptions of the financial and accountability aspects of clinical work (that is, between financial realism and transparent accountability and clinical purism and accountability to self, peers, and patients (or opaque accountability)).

The consistency in the views of each professional group in the different countries is striking. The professions tend to conceive of clinical work in the following ways:

Healthcare professionals' stances on the key elements of health service modernisation

	Medical clinicians	Medical managers	General managers	Nurse managers	Nurse clinicians
Recognise connections between clinical decisions and resources	Oppose	Support	Equivocal	Support	Oppose
Transparent accountability	Oppose	Support	Support	Support	Oppose
Systematisation	Oppose	Oppose	Support	Support	Equivocal
Multidisciplinary teams	Oppose	Oppose	Equivocal	Support	Support

- General managers hold strongly systematised conceptions of clinical work and financial realism and transparent accountability
- Medical managers tend to hold individualist conceptions of clinical work and to support financial realism and transparent accountability
- Medical clinicians hold strongly individualist conceptions of clinical work and are equivocal about financial realism and transparent accountability
- Nurse managers tend to hold systematised conceptions of clinical work and to be somewhat equivocal about clinical purism and opaque accountability
- Nurse clinicians hold systematised conceptions of clinical work and strongly support clinical purism and opaque accountability.

The table shows how each professional group's conceptions of clinical work relate to the four key elements of modernisation. Given the media and historical depictions of ongoing tension between doctors and managers referred to earlier, the results may be surprising. Nurse managers, not general managers, are the professional group most supportive of modernisation.

Implications of professionals' differing views

These results suggest that Edwards and Marshall are correct when they effectively attribute tensions between doctors and managers to differing professional cultures. Some members of the medical profession may believe that these results confirm the willingness and ability of doctors to resist what they perceive to be the imposition of wrongheaded changes. Alternatively, policy makers and managers may regard the results as providing evidence of medical intransigence and providing justification for redoubling efforts in existing top-down approaches to reform.

Each of these conclusions is mistaken. Celebrations of medical resistance misjudge the extent of the societal forces in play. Specific details of the health reform programme (in each country) mirror reforms in other services such as education and welfare. The impetus for reform lies not just with the minister of the day and his or her advisers but also within society at large. The drive for efficiency reflects a well established shift in public sector management, driven in large part by the public's desire for lower taxes.[17] Moves to strengthen the accountability of clinicians are matched by similar efforts in other trust based endeavours such the priesthood and the legal system.

The recent explosion of performance targeting and monitoring suggests that policy authorities try to overcome (medical) resistance at the implementation stage by amplifying the scope and reach of performance management and creating new regulatory structures. Such responses, however, contain the seeds of their rejection by clinical staff. Focus groups in Wales showed, for example, that clinicians of all disciplines are critical of what they perceive as a blind and unrelenting drive on increased throughput and reduced waiting times that inappropriately skew clinical priorities.[14] Clinicians are also highly critical of the time now absorbed by "management generated and oriented (paper)work" "totally lacking (in) clinical significance." These (often valid) conclusions provide grounds for further resistance. The political importance of the NHS to the present government, however, means that policy efforts on these issues are likely to increase rather than decrease.[2 18]

The persistence of tensions, resistance, and bureaucratisation in health care has resulted in a seemingly unending and discordant medical and management "two-step." This is strange, not just because many managers have a medical background,[1] but because it suggests an apparent lack of awareness or interest by policy makers, local managers, and doctors in the potential contributions that other professions, most notably nurse managers, can make to reform.

The multidisciplinary, team based systems that nurse managers champion—in particular, integrated care pathways for common types of cases—provide the basis for re-establishing "responsible autonomy" as the primary organising principle of clinical work. Fully developed integrated care pathways specify the agreed sequence of diagnostic and therapeutic processes and incorporate the views of (medical, nursing, and allied health) clinicians and managers, which (in the light of the available evidence, stated resource constraints, and experience of patients) are essential for achieving desired outcomes for specified clinical conditions.[19–22] They therefore provide a tool for empowering clinicians to strike a balance between the clinical and resource dimensions of care and between the requirements of both clinical autonomy and transparent accountability.

Given the various conceptions of clinical work, our suggestion that doctors and managers engage more directly with nursing and allied health professionals when responding to reform initiatives is likely to be rejected as both culturally difficult and destabilising to established positions of power. We would argue, however, that continuing to refer to healthcare issues as primarily a medical and management debate narrows the range of alternative and perhaps more constructive approaches that may be taken to reform issues.

Conclusion

We believe that, left unresolved, the "danse macabre" that has characterised health systems reform will have three effects. Firstly, it will undermine opportunities to incorporate the perspectives of clinicians in local modernisation strategies. Secondly, it will prevent the revival of "responsible autonomy" as an organising

principle in health care. Finally, it will mean that all parties will continue to be driven by the distrust and related crises of confidence that pervade the field.

Competing interests: None declared.

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Improving the doctor-manager relationship

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The problem with doctor-manager relationships is well studied. The potential for these relationships to harm the working environment and affect organisational performance is acknowledged and understood. The same is not true of possible solutions. To bridge this gap we invited short contributions, and we are publishing a selection of these to start the debate. This is the kind of issue where those from different sides might wish to contest all the potential solutions. We hope so. Please post your responses on bmj.com

Doctors and managers: mind the gap

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The US healthcare system is characterised by uneven quality, very high cost relative to health outcome, and patchy access, particularly for those lacking adequate health insurance coverage. These performance gaps in the system were described as a "chasm" in a recent report from the Institute of Medicine's committee on quality of health care.[1] Many observers (including doctors and managers) agree that little research has been done on the impact of management on improved performance of healthcare delivery systems. I propose here a seven point plan to seek common ground between doctors and managers.

Firstly, we should foster interdisciplinary education for managers and physicians at the earliest possible stage in professional education. Managers could do clinical rounds and clinicians could attend management programmes.[2] A deeper understanding of each other's culture will help to improve relationships and quality of care.

Secondly, we should develop the management research agenda through the Agency for Healthcare Research and Quality, the US federal government body for research in this arena. The agency needs $1bn (£0.6bn; €0.9bn) to tackle the challenges identified in the Institute of Medicine's report.[1] Better management research will enable us to redesign care processes based on best practice and to coordinate care more effectively over time.

Thirdly, we should encourage measurement and assessment of clinical performance. We need a national system of clinical accountability with robust measures that make sense to individual clinicians and managers. Currently, performance assessment tools in the United States can support quality improvement only in the practice environment (Daley J et al, unpublished data) as they lack specificity at the level of individual physicians. The tools are inadequate for rewarding clinical excellence on the basis of current measures.

Fourthly, we should promote the widespread implementation of a combined managerial and clinical report card when the performance of healthcare institutions is being reviewed. Regular, annual, quality