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Involving Doctors in Management: Key Concepts and Challenges for today's NHS

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Introduction

The objective of this study was to focus on UK clinicians' own perspectives on (non-) engagement in management at a time when the NHS was in a period of organisational and management change. The study was both qualitative and quantitative in construction. It applied **personal construct theory** so that the selected participants' views on management could be drawn out, rather than any potential biased views that the researcher/interviewer might hold.

Methods

Semi-structured interviews with five clinicians currently involved at a senior manager level were held to create a survey that was subsequently sent to 80 consultants within an NHS organisation to elicit their views using a Likert scale.

The study was carried out within a theoretical framework of personal construct systems developed by **George Kelly**, a social psychologist in the USA in the 1950s, (Kelly 1955) as a paradigm for exploring the ways in which **individuals interpret and make sense of their intrapersonal and interpersonal worlds**.

Fig. 1: George Kelly (from http://webspace.ship.edu/cgboer/kelly.html)

Eliciting an account of people's key constructs allows the researcher "to stand in others' shoes, to see their world as they see it, and to understand their situation and their concerns." (Fransella, Bell & Bannister 2004). Personal construct theory suggests that all people create and re-create an implicit theoretical framework that informs behaviour. Constructs are theorised to be bipolar.

Thus, when an individual affirms his/her views on one issue, he/she is simultaneously saying whatever the opposite or difference is, however, this opposite or difference is self-constructed. In affirming his or her views, the individual offers up an *emergent* pole, which also means that he/she offers up a so-called *implicit* pole which can be elicited through the research process. This allows contrasts to be determined and a 'grid' built. Using monadic elicitation, this approach focussed on five areas of interest highlighted by the literature: **skills and standards; interest and career; role pressure/ time; clinical conflict; and resource management and organisation.** The data was analysed using WebGrid III freeware (Shaw, M. & Gaines, B., University of Calgary).

Results

A number of key themes, evidenced in previous research, were identified:

- Doctors believe they should be involved in management decisions, which is supported by previous evidence outlining their unique and valuable understanding of health care.
- Doctors cite lack of time and a lack of support and training as reasons for not engaging.
- Doctors revealed a desire for non-clinical managers to get a better understanding of the clinical viewpoint and a need for further national benchmarking in terms of audit in order to make it more meaningful.
- Doctors enjoyed multi-disciplinary team working and were willing to offer their views on organisational structure in the belief that their knowledge and skills could be of benefit.
- Doctors become involved in management both as a defence mechanism and also because they have a moral and ethical responsibility to be involved.
- Doctors may have a problem understanding management, be unclear about the expectations of their role and do not see a notable career path for themselves in management.
- Doctors find management decisions difficult, for example, in terms of understanding and then employing management terminology.

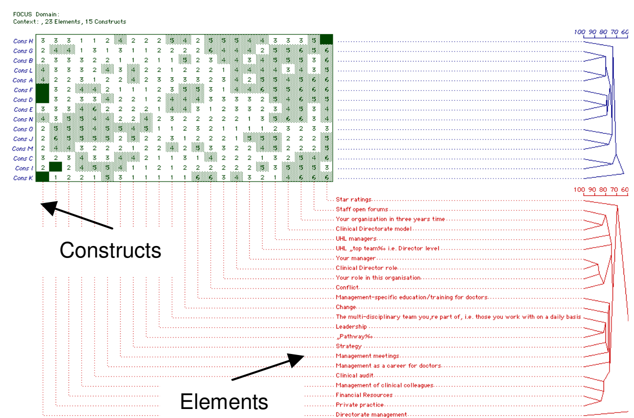

Fig. 2: WebGrid III clustering showing the relationships between different elements

Conclusion

Of the five areas cited above, 'interest and career' focused most on the motivational factors around clinical involvement and there was **real willingness from respondents to involve themselves further in management roles**, although with questions about how they could be supported to do this. In addition, there were questions raised over **whether their role should be a management one or more focussed towards leadership**.

Recommendations

1. Respondents to this research wanted **more training and development**. This should be set up more formally in all NHS organisations. Formal career paths could also be introduced, although the blueprint for this should emerge from the training and development that is undertaken.
2. **Managers should be more involved in understanding what clinicians have to offer** and should encourage and facilitate their involvement by first spending more time trying to see things from the clinician's perspective (There is an argument that managers who don't add value to the wider clinical process should have their roles re-evaluated and reassigned so that a better, more coordinated approach to decision-making can be established. This would make clinicians more confident that their management colleagues are focussed on joint goals and policies).
3. Given respondents felt their roles to be enjoyable, were supportive of team working and welcomed change, **any future methods of delivering the 'improvement agenda' should be tackled collaboratively**, across professional boundaries without leaving anyone behind in terms of knowledge and understanding.

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