Involving doctors in management

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Involving doctors in management:

Key concepts and challenges for today's NHS

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Synopsis

The aim of this study was to investigate the key factors that influenced the involvement of doctors in management and to see where doctors' involvement in management could be extended.

A review of the previous literature endeavoured to find out what evidence already existed to support doctors' involvement in management, as well as to ascertain the factors that meant they did not engage in the non-clinical agenda. This drew out a number of themes, which were to form the basis of the key national and local indicators of the so-called "management agenda" that were put across to a number of senior clinicians in interview and via a survey.

Adopting a Repertory Grid methodology (as devised by George Kelly) to draw out these views allowed interviewer bias to be eliminated from the study and the results indicated that doctors were supportive of further training and self development with regards to management issues.

In addition, consultants revealed a desire for non-clinical managers to get a better understanding of the clinical viewpoint. The results demonstrated that there should be further national benchmarking in terms of audit in order to make it more meaningful, that respondents enjoyed multi-disciplinary team working and that they were willing to offer the organisation their views with regards to their interests and skills and the structure of the organisation.

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Introduction

It could be argued that the issue of involving clinicians in management has always been on the agenda of the NHS. The Griffiths Report was perhaps the most obvious attempt at creating a management agenda for health care and the Harvard Clinical Directorate model was adopted in the late 1980s by Guy's and St.Thomas' Hospital in London as a way of involving doctors in this process. Yet, despite this, over the past 30 years there has been some reticence amongst clinicians to become involved in what are often seen to be "administrative" duties. This, of course, needs to be put into some sort of context.

Cyril Chantler (1999), one of the early UK pioneers of the clinical directorate model and a doctor-manager of some renown, has done this eloquently. Despite advances in medical technology, he argues, doctors have never been able to do so much for patients, yet their public image has never been at a lower ebb. Governments have never spent more on health care, yet demand still seems to outstrip capacity thus making all who work in the NHS feel starved of resources.

With improvements in technology keeping people alive longer, comes a greater burden of morbidity. Taxpayers are keener than ever to see public money spent wisely and governments, equally as keen for success at the ballot box, do not want to raise taxes to fund improvements, yet those who are ill believe that every treatment they need ought to be available when they need it. This means that an

already stretched service is still further stretched and that clinical leaders are faced with many difficult dilemmas (Simpson 2000 p.2).

Furthermore, doctors' involvement in management has a lot to do with their relationship with non-clinical managers, who are responsible, in the UK health system, for implementing government policy, which has become, over the past eight years, strongly directed at modernising the health service and gaining maximum value for money out of those who operate in it.

It is striking, that despite the high profile the NHS has been afforded, and the record levels of investment sunk into it, clinicians of all levels at a Belfast hospital were unfamiliar with the initiatives under way since 1997 and the key principles of the New NHS (Curley at al. 2002). Perhaps this is simply representative of clinicians with regard to the latest centrally determined NHS initiatives.

Present and forthcoming challenges acknowledged by a group of UK medical directors included hospital acquired infections, payment by results and patient choice, the consultant contract, "buy-in" on targets, notably the four hour wait for emergency departments, the European Working Time Directive and Agenda for Change, a restructuring of NHS contracts across all grades (Health Service Journal 17 June 2004 p.28-31). It could be argued that eight years ago, of all of these, only hospital-acquired infections would have been on the radars of senior clinicians, such has been the emergence of such centrally-dictated 'management' policy.

The "involved" clinician, therefore, sits between two systems, one of which is the collegial, professional world, where he or she sits as a peer to colleagues with a set of specific clinical skills, governed by professional standards, codes of practice and ethics, whilst in the other, he or she sits taking a wider view of the organisation, mapping out its future track based on clinical knowledge and experience, with managers who are accountable, ultimately, to politicians (Simpson 2000 p.2). This "wearing many hats" is extremely difficult, forcing a clinician, "…at one moment to represent a clinical discipline and then ten minutes later to disadvantage that discipline to the greater corporate need of another area or of the trust or NHS at large." (Hopkinson 2000 p.5)

It is against such a backdrop of confusion and clarity regarding clinician involvement that these areas of literature need to now be considered.

Literature Review

There are some key questions that need to be addressed in understanding doctors' involvement in management. The reasons for why doctors become involved, as well as their reluctance, need to be considered. Where doctors are involved, their level of participation needs to be understood to inform future involvement in health care service planning and delivery. Alongside this, consideration of where that leaves their current involvement is necessary. However, the first area to consider is how doctors started to become involved in the management agenda.

A brief history of clinician involvement

The first real attempt at planning hospital services in 1962 could be seen as the earliest endeavour to involve clinicians in management and McClelland and Jones (1997) cite evidence that attempts to involve doctors in management date back at least to the Cogwheel Reports of 1967-69 (p.1).

Work by Allen (1995 p.45) suggests that the Yom Kippur War and oil price rises, coupled with the International Monetary Fund lending the United Kingdom money in 1975 meant that the unchecked expenditure of the NHS could no longer afford to rise at a real rate of 3-4%. A further concern was the changing population structure and patterns of illness (Dopson 1994 p.25) and moreover, there seemed to be significant local and regional inequalities in terms of the allocation

of funds to different parts of the country. The emergence of the Resource Allocation Working Party (RAWP) in 1975, which recommended that resources should be allocated more evenly across the country, meant that the need to get a handle on expenditure and distribution of resources could no longer be ignored.

Furthermore, in 1976 the Priorities Document recommended that money should be directed away from the acute sector towards long-stay services (Allen 1995 p.45-6), adding further pressure to hospital-based services.

The 1980s saw the then Managing Director of Sainsbury's, Roy Griffiths review management within the NHS. The NHS Management Inquiry (DHSS 1983) report in October 1983 made a series of recommendations, emphasising the role of doctors in management and proposing the start of clinical budgeting. This reorganisation dispensed with the system of consensus management and replaced it with a general manager from any discipline, whose role it was to stimulate ‘initiative, urgency and vitality’ among staff (Dopson 1994 p.27).

The Inquiry proposed that the development of budgets at unit level would lead to closer involvement of clinicians in managing resources and allow service objectives to be related to financial and workforce matters. The cultural change from the administration to the management of health services with clinical professionals playing a key role had begun (Austin and Dopson 1997).

In 1989 the government proposed a new White Paper ("Working for Patients") (Department of Health 1989) that sought to impose managerial and fiscal discipline on clinicians through external influences, such as General Practitioner fund holding (in essence this gave GP's a budget of their own and the freedom to negotiate the provision of certain services wherever they wished, including with private providers) (Allen 1995 p.46). This approach was embodied in the Resource Management Initiative, which sought to encourage doctors to take responsibility for the resource implications of their clinical activities.

A tangible outcome from the implementation of this policy was the establishment of the position of clinical director (Sutherland and Dawson 1998 p.S19). According to Willcocks (1997) and Austin and Dopson (1997), the role of the clinical director was to influence their colleagues to think about the future development of the service in the context of limited resources and a more competitive environment. Clinical directorates or divisions continue to be the predominant model for involving doctors in management in today's NHS (Willcocks 1994 p.68) and despite being originally set up to manage budgets, their responsibilities now include outpatient scheduling, inpatient admissions, clinical governance, public and patient involvement and medical and nursing resource management.

Why doctors get involved in management

Writing in 1994, Saxton summarised the main reasons for why doctors should be involved in health care management. Not only did he suggest that doctors were best placed to make resource decisions, they also provided continuity and (some) a 30-year perspective of health care, coupled with an independence not shared by career managers. The argument that, if doctors were not to manage, somebody else usually will was also cited as a reason for their involvement (p.4) and Saxton also believed that doctors should have something to offer. This is supported by Balderson and MacFadyen's study of Leicester (1994), which stated that, in 1985, 94% of doctors surveyed who had qualified ten years previously indicated strong feelings that doctors should participate in NHS management." (p.17)

The 'natural manager'

Authors such as Bruce and Hill (1994) support the Griffiths Report suggestion that, "The nearer the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers." (DHSS 1983) They assert that, "…doctors should be regarded as natural managers…it is doctors who largely dictate the use of resources and who as such ought to accept the management responsibility that goes with clinical freedom." (1994 p.1)

This view is also supported by Horsley et al (1996). From the time they qualify, the authors write, they manage their own time, their patients' care, and their immediate medical and other staff (p.1), so they are already practising as managers. They deliver a complex service, through the coordination, motivation and training of others (Allen 1995 p.48), their prior medical training enabling them to contribute in a critical way to the strategy, appropriate allocation of resources and to improving the quality of care (Fitzgerald 1994 p.38). Those skills are exactly the same ones required in any modern-day manager's toolkit. Marnoch (1996) further believes that the issue of credibility, in assessing patients and measuring the benefits to them of their interventions, makes it vital for government to get doctors' actively participating in the management process.

Making the best use of limited resources

However, the 'cost' agenda never seems to be far away. Walker and Morgan (1996) provide evidence that, "One of the many reasons for encouraging more doctors to become involved in management appears to be to save money by reducing overspending within the NHS and to assist with managing financial problems." (p.2) They go on to say that controlling this expenditure cannot be realised without the cooperation and active participation of doctors.

Buchanan et al. (1997) indicated that doctors' decisions commit hospitals to expenditure for which the same doctors are not accountable and that the Griffiths Report was an attempt to introduce "…clear management lines of responsibility

and accountability, with general management posts at district and unit levels, and with these posts held (with BMA support) by doctors." (Buchanan et al 1997 p.2)

According to Chantler (1999) doctors therefore had to have regard for efficacy (does the treatment work?), effectiveness (how well does it work in practice?), efficiency (is the maximum output obtained for the minimum input?), equity (are those most in need receiving priority?) and economy (is the expense justifiable compared with the opportunity cost?) if they were to play a positive part in health care management.

<u>A unique and valuable understanding of health care</u>

Many more compelling arguments have been made for doctors to be involved in management. Sutherland and Dawson (1998) proposed the view that clinicians and managers had the potential – by working together – to bring about massive change in the NHS, tempering concerns for the individual patient with those of the 'bigger picture' of population health, considering costs and effectiveness alongside value for money (p.S22)

Doctors' unique understanding of health care issues places them in a position to understand the rationale for change and improvement better than non-clinicians. Evidence from Ireland suggests that managers and clinicians are inseparable, as "…managers cannot hope to implement plans for resource allocation and service development without the support and co-operation of the clinicians" (McDermott

et al. 2002 p.38), whilst one current UK acute hospital medical director believes that "…the key issue for the medical manager is to ensure that the financial and business planning parts of the organisation understand the clinical issues and priorities." (Hopkinson 2000 p.4)

Seen alongside work by Fitzgerald (1994), who argued that it was,"…virtually impossible to imagine how managers, in isolation, could carry out the tasks required to specify the type, form, quality standards and volumes of a specific medical service without the active involvement of the clinical specialists," (p.37) this makes the case for integrated working with career managers even more convincing.

Further reasoned arguments for doctors to engage in the management process are provided by a number of authors (Buchanan et al. 1997; Willcocks 1998; Walker and Morgan 1996), who assert that doctors contribute a valuable clinical-scientific perspective, which could lead to clearer service objectives, better planning, improved budgetary control, faster decision making and flexibility to respond to changing demands, all to a specified cost and quality.

Self-satisfaction and benefit

Moreover, doctors are often best placed to focus on health outcome or patient satisfaction and away from a pre-occupation with resources and costs, thus ensuring resources are devoted optimally to serve the interests of patients. In

doing so, Hoffenburg (1987) believed doctors would find that their own clinical freedom was maximised.

Chantler argued that clinicians would benefit their patients most by taking their share of the responsibility for managing the system, which would enable them to better maintain their professional integrity (1999 p.3). His argument, more so than Hoffenburg's, takes on an almost religious sensation, stressing doctors' moral and ethical responsibility to be involved.

Indeed, doctors involved in management have found a great deal of satisfaction out of their own participation, enjoying having a 'finger on the pulse' and solving others' problems (Buchanan et al 1997 p.6). One respondent in the Buchanan et al study, "…claimed involvement in management had enhanced the status and feelings of self worth of medical staff" (p.7), which indicates that there is an obvious desire and motivation to influence the care provided and to improve on past decisions (Fitzgerald 1994 p.42).

Management as a defence mechanism

Ong et al. (1997) and Fitzgerald (1994) provide evidence that clinicians adapt opportunistically and are able to adopt managerial orientations, which allows them to influence resource allocation decisions to safeguard clinical boundaries. This suggests that they are assuming new and powerful managerial roles (as clinical and medical directors) in a calculated fashion to ensure that decisions go

in their favour. They defend and control peer review processes such as clinical audit, evidence-based care and the development of protocols and guidelines, despite the fact that these are also used by managers to improve the quality of service delivery.

Another reason for their involvement is to do with the fear of being managed if they do not actively become engaged (Dopson 1994 p.32) and some doctors choose to pursue a different career option as their first career reaches its twilight, whereas many get involved because all of their colleagues have 'had a go' and it's now their turn. Others, whilst genuinely interested in seeing how management could improve their service (Austin and Dopson 1997), have witnessed opportunities not being pursued or benefits of being stifled in the past (Buchanan et al. 1997 p.11) and have a genuine concern about the quality of NHS management (Dopson 1994 p.32).

The reluctance of doctors to get involved in management

What is management?

There is some reluctance to get involved in management for the simple fact that many clinicians are unsure exactly what management is or what its purpose is.

Is it "deciding what should be done and getting other people to do it?" as suggested by Rosemary Stewart (and quoted in Sutherst and Glascott 1993 p.25) or does it mirror the industrial perspective of Fayol?[1]

Marnoch (1996) says that the ambivalent relationship doctors have to management is due to a lack of agreement over whether it is a function – the overall steering or directing of a unit or organisation; a set of activities – carried out in order to bring about the steering and directing; or a team of people – responsible for the steering and directing. This confusion over what management is, he argues, part of the reason for a failure to engage.

Management is all of these, but in the context of the NHS, Buchanan et al. (1997) believe that the process of management in the NHS can be defined as an ongoing series of activities concerned with strategic goal setting, operational decision-making, and resource allocation (p.2). There is therefore a need for doctors to understand and be aware of the system in which they work and the processes that are connected to that system functioning.

<u>Clinicians and managers inhabit different worlds</u>

According to Dopson (1994), doctors do have the power to influence patterns and priorities of health care, but the reality is that doctors and managers have very different interests and perspectives (p.28). Managers are "…trained to be

[1] Fayol suggested that management had five functions: to forecast and plan; to organise; to command; to coordinate; and to control.

aware of the wider implications of any activity within the organisation," whilst doctors "…are expected to strive for the best available evidence before making a decision" (p.28) and rarely receive any management training until they are quite senior.

For example, for an outpatient facility to function there is a need to see beyond the doctor-patient interaction, to the planning of that clinic, the other staff involved, the referral from and back to the General Practitioner as well as the support services, which allow that clinical episode to occur. This involves the need to understand change, motivation, communication and administration as well as management and leadership (Sutherst and Glascott 1993 p.26-7).

Dyson (1994) believes that doctors already understand these functions, through their responsibility for the clinical management of patients. He cites the example of hospital doctors with admitting facilities, stating that not only are they responsible for the clinical management of the individual patient from diagnosis through to treatment, but they are also responsible for managing inpatient and/or outpatient waiting lists and the management of the multidisciplinary team, which provides the care. The difficulty comes not from the fact that doctors carry out these tasks, but that there is a reluctance to see them as management (p.10).

Research by Willcocks (1998) that doctors are confused about what should be expected of doctors in regard to NHS management, (p.2) is reinforced by Bruce and Hill (1994), who have found that, "Where senior managers were clearly of

the view that the medical director was part of the managerial hierarchy, doctors often held an opposing view, to the effect that the medical director ought to be regarded as the voice of the medical profession.” (p.4) Rather than being seen as the “…rational, level headed “engines” of the health service, ensuring there are sufficient resources to keep clinical services operating” (Sutherland and Dawson 1998 p.S17), managers were seen to have an overriding concern with costs and efficiency, despite the fact that the improvement of patient care continues to be a key overlapping objective of both groups (p.S22).

Therefore, there appear to be key distinct differences between clinicians and managers in terms of their values, allegiances and mindsets and research by Gatrell and White (1996) found that only about 30% of doctors were receptive to the concept of management. This would appear to reflect that there was still disconnection in hospital, “…between those at the top who organise the strategy and those at the service end who deliver care to patients” (Chantler 1999 p.4).

Conflicts, conflicts everywhere

According to Willcocks (1998), research by the relative professions pointed to tension between different tiers created by the internal market reforms of the late 1980s, notably between the Trust Board and clinical directorates (p.2). This potential conflict between central control and devolved budgeting led to problems with achieving meaningful decentralisation and there were inherent problems

with the structures within which doctors themselves operated, such as not having the time or experience to add value to the process.

"Time" or the lack of it is cited by a number of authors for why doctors resist management (Saxton 1994, Balderson and MacFadyen 1994, Corbridge 1995, Fitzgerald 1994), or more precisely the time taken away from being a clinician because of their involvement in management to the detriment of their clinical activity (Balderson and MacFadyen 1994 p.17). Furthermore, some doctors are dissatisfied with unrealistic government targets and excessive paperwork (Buchanan et al 1997 p.6).

Helping to make decisions with managers about the use of resources involves consideration of their finite nature and of the opportunity cost of using that money in a certain field. Many doctors see this conflict on the horizon and, preferring not to get into the rationing debate, as Mathie (1997) puts it, "proclaim clinical freedom" (p.2) as a means of avoiding alienating themselves from their colleagues when managerial decisions conflict with clinical ones.

In addition, the absence of a notable career path for doctors in management has led many to avoid participating (Austin and Dopson 1997). Moving into management was seen as a full-time commitment and few doctors were willing to make, what they considered, an irrevocable move (Fitzgerald 1994 p.35). Another factor that is often belittled by doctors for why they don't get involved in management is that some fear management may actually be difficult, citing

problems dealing with colleagues, understanding and then employing management terminology and facing isolation and hostility from colleagues as issues that mean they may perform poorly in the role and risk failure (Fitzgerald 1994 p.41).

The issue of time can thus be broken down into one of worry about levels of clinical activity, alongside concerns about having the actual time to do 'full-time' management tasks and activities in a 'part-time' role (Fitzgerald 1994 p.35). Early research by Willcocks (1994) supported the view that role overload, ambiguity, incompatibility and perception were just some of the barriers preventing meaningful clinician involvement in management (p.69).

In addition, the issue of private practice is mentioned by some authors to account for why some clinicians do not get involved in management (Saxton 1994, Dopson 1994).

<u>Management through government</u>

An additional factor is the regard that clinicians have for management, based on their experience of NHS managers. Many see management as an "…attempt to subordinate their professional autonomy to the goals of the organisation" (Ong et al. 1997 p.90), with managers, directed by central government, making significant inroads into the decision-making process at the expense of the professionals with all the clinical knowledge, thus demonstrating their discomfort with the notion that

decisions affecting patient care are taken by non-clinicians (Buchanan et al. 1997 p.2).

The more cynical amongst them find it hard to accept that management has any sort of academic base, let alone that it has a robust, if young, academic tradition (Scott 2000), which means they treat managers with a low status and view their own participation in management, other than where absolutely essential, as "…a direct attempt to erode their clinical autonomy." (Walker and Morgan 1996 p.2) There is also indifference to the short term nature of health care planning and the role of political agendas, with even students of medicine seeing little relevance of politics to health and resenting the concept of cost benefit to clinical decision making (McClelland and Jones 1997 p.4).

However, whatever the funding arrangements, Scott (2000) believes there is always some accountability to government, as health care is high on individual citizens' agendas and an issue on which governments can fail or succeed. He believes there is a perpetual struggle for clinicians to reconcile their personal clinical responsibility with organisational or health care system accountability.

A lack of support and training

In addition, there is the issue of whether doctors have been adequately supported and trained to take on management roles. Austin and Dopson (1997) suggest that doctors are used to working to the best available evidence before

making a decision, working to short-term individual patient goals, yet rarely receive any training in management or organisational skills until they become a consultant. Research by Horsley et al. (1996) indicated that clinicians were expected to do both their own jobs and be managers, spending ten or more years training for the former, yet receiving nothing to perform the other (p.4).

Rowland Hopkinson (2000), a Medical Director in Birmingham, agrees. He states a number of reasons for non-involvement, namely that "…there is token management training for trainee doctors and little incentive to understand the discipline of management." (p.6)

Doctors' leaders state that the failure of the government to face up to what the involvement of doctors in management means in resource terms (Dopson 1994 p.32) and a fear of alienating colleagues and undermining clinical relationships, added to the impact of management work on clinical work, means that doctors are unwilling to play an active part in the present and future determination of resources, especially when they view the NHS as having to live within resources that are totally inadequate for health needs.

Where does that leave clinician involvement in management now?

Training and development

In a study carried out over a decade ago in Leicester, Balderson and MacFadyen (1994) found out that doctors lacked key skills and knowledge in financial matters, conflict management, leadership and team management skills, time management skills and understanding the system and how to operate within it (p.17). These challenges were evident in a study by McClelland and Jones (1997), who outlined the need to acquire the full range of expertise in finance, business planning, personnel management, marketing and strategy formulation. (p.2) Training could also enable doctors involved in management to learn how to get the best out of their colleagues and should include the elements of "…communication, counselling, dealing with complaints and approaches to professional discipline." (Owen 1995 p.7)

Successive studies by Gatrell and White (1996) and then Buchanan et al. (1997) have shown that a narrowly defined set of principles can be identified where efforts to train and develop clinicians in the 'ways of management' are possible. These focus on skills and awareness training and build on the already honed skills that clinicians possess. More detail of these can be found in Appendix A.

A change of approach on both sides

Despite the fact that, at a national level, with the reforms of 1974, 1982 and latterly of 2000 ("The NHS Plan"), doctors have taken a lead in securing a position of influence in the formation of policy, representatives of the profession have shown themselves to be unwilling to give time to the demands of management because of many of the reasons already outlined above.

Clinicians have seemingly adapted well to technological and scientific advances, driving them to adopt new treatments for the good of their patients but this doesn't seem to have affected their attitudes to the changing nature of their role in health care and the need to work within multi-disciplinary teams (McDermott et al. 2002 p.45). This obliged cooperation has brought to the fore the cultural difference between clinicians and managers, which, as McDermott et al (2002) describe it, "…militates against meaningful cooperation." (p.37)

By integrating their medical and managerial skills, they accept a certain loss of personal and professional autonomy and this shift from individual patient responsibility to a concern for the wider population turns the clinician into a resource "allocator" facing difficult decisions on which services to restrict to fit with the available funding (McDermott et al. 2002 p.38).

However, there is evidence that most clinicians believe managers should have some capacity to challenge the dominance of the medical profession and that

their clinical autonomy should be largely restricted to the individual patient-doctor relationship and not whole health systems decisions (Bruce and Hill 1994 p.3).

Perkins (2004b) believes that contemporary health sector managers and leaders are expected to engage in quality improvement (including measuring what they do), improving outcomes for patients and risk management.

He cites research undertaken in Australia, New Zealand and the United Kingdom, which suggests that medical clinicians as a group reject multidisciplinary teams, transparent accountability systems and efforts to introduce control systems into clinical practice.

Moreover, he believes that securing clinicians in leadership roles will provide the health sector with a vital opportunity to get both buy-in and a chance at control. A successful example of this comes from one UK acute trust, underpinned by a shift in attitude amongst consultants, whereby the process of understanding patient complaints caused by long waits in A&E turned out to be a catalyst towards accepting the legitimacy of targets as a measure of patient care (Health Service Journal 17 June 2004 p.31).

However, despite the best efforts of both groups to educate, train and inform each other about their respective roles there will always be that group of doctors, as described by Dopson (1994), "…whose members bury themselves in a hole and look after their patients and then pop up every now and then and say how

bloody awful it is then disappear again," (p.32) alongside the other group that understands the bigger picture and realises that sometimes individual sacrifice needs to be made for the sake of the hospital or wider health community.

The future outlook

The work of Buchanan et al. (1997) describe doctors' participation as reluctant, transient, pressured, service-driven and power-pulled and their future involvement appears unpromising, with "…a potentially unpleasant job that combines the pressures of time, money, staffing issues and clinical workload, with insignificant financial rewards and limited career benefits." (p.11) Nevertheless, in a 2002 study of Irish hospital consultants, two thirds felt that they should act in an advisory role and in partnership with managers, rather than taking a superior role in relation to managing the managers (McDermott et al 2002 p.45). There was a belief that, having the respect of clinical peers and working together with managerial colleagues, the successful clinician was able "…to see initiatives through, taking time to talk with colleagues, clarify issues, facilitate communication, manage conflict, outline the vision, build consensus and, if that is not enough, energise the change process." (McDermott et al. 2002 p.44)

Given such a forecast, this research was undertaken to examine why consultants at University Hospitals of Leicester (UHL) NHS Trust would choose to become involved in non-clinical issues that are often deemed the responsibility of NHS

managers by ascertaining their views on a number of national and local issues. It aimed to find out what motivated these doctors to get involved in the management and government agenda.

This research sought to find further reasons and explanations for why doctors were motivated to extend their involvement in health care beyond their clinical day-to-day responsibilities and become involved in issues that underpin the running of the NHS.

Method and Approach

This study was undertaken between November 2004 and March 2005. Primary data were collected from two sources: five face-to-face interviews with clinicians deemed by their roles to already be involved in management at a senior level in the organisation and through a postal survey, derived from the interviews, which was sent to UHL consultants.

The methodology adopted the Repertory Grid technique, originally devised by George Kelly, a social psychologist in the USA in the 1950s. Kelly devised this technique as a method for exploring personal construct systems. As Fransella et al. (2004) express it, Kelly's theory was, "…an attempt to stand in others' shoes, to see their world as they see it, and to understand their situation and their concerns." (p.6)

The theory suggests that all people create and re-create an implicit theoretical framework and further to that, in affirming their views on one thing, they are simultaneously saying whatever the opposite or difference of that thing is, however they, as people, choose to determine that opposite or difference. In affirming their views, they offer up an *emergent pole*, which also means that they offer up a so-called *implicit pole*. In essence, this means that constructs are bi-polar, which allows contrasts to be determined and a 'grid' to be built.

This approach was *loosely* based on Kelly's 'classic' repertory grid theory. 'Classic' repertory grid theory follows a procedure very similar to the "Which of these things is not like the others?" game [2], in which participants are presented with three objects and asked to say which two are most similar to one another and what makes them different from the third, referred to as eliciting the triadic difference. This process is repeated until no new points of difference emerge and the resulting list of differences is then used as a starting point for collecting quantitative data such as attribute ratings and similarity judgements.

The key reason this methodology was chosen was to avoid any interviewer or researcher bias regarding the research question. There was certainly potential for a current NHS manager to hold preconceived ideas about what NHS consultants might think about issues such as 'star ratings' and 'UHL managers' and their general involvement in management. Asking doctors to rate their views on themes such as these according to pre-determined attributes could lead to implicit bias in this study.

The repertory grid technique used in this study identifies which attributes participants themselves use to distinguish one theme or concept, without any researcher bias. This technique is extremely powerful as it does not assume a pre-defined framework (as a standard survey would) and then try to 'fit' everyone into a limited set of 'boxes'. The boxes are determined by the interview

[2] my appreciation goes to Mary Ellen Gordon and David J. Rowe of *Market Truths* for this explanation of Repertory Grid Theory on their fascinating and informative website www.markettruths.com

participants, which then allows a survey to be constructed for the survey participants to choose where to place themselves.

Adopting a less complex approach than 'classic' theory, the researcher used a phrase such as, "What comes to mind when you think about…?" or "Tell me what your initial thought is when I say the following word…" to introduce a series of themes or concepts, known as *elements*, to obtain the views of the interview participants. This is known as monadic elicitation, as compared to dyadic (contrasting two elements) or triadic (contrasting three elements). This was partly done to keep the interviewing and surveying simple, in recognition of the fact that asking a consultant to see similarities in two concepts such as 'conflict' and 'staff open forums' and how they differ from a third concept such as 'your manager' was confusing. However, this simpler approach was also adopted because it would offer contrasting views that other consultants could easily align themselves along (using a Likert scale) when answering the postal survey. The elements were pre-determined, or 'offered' by the researcher so that control of the process could more easily be guaranteed and because these elements were the significant and relevant ones that came out of the literature review.

The review of the literature suggested around forty pertinent questions that could be asked of doctors about their role in management. These questions are presented in full in Appendix D. Using the repertory grid technique, it would have been beyond the scope and scale of this research to consider each of these forty concepts, especially as many had been previously covered and debated in the

existing literature. However, it was possible to group these concepts into five thematic areas of particular relevance to the subject area, which were as follows:

1. Skills and standards;
2. Interest and career;
3. Role pressure/time;
4. Clinical conflict;
5. Resource management and organisation

In order to explore the relevance of the above concepts and thematic areas to the local as well as the national picture, twenty-three *elements*[3] were decided upon, which were a mixture of abstract ideas (such as ‘leadership’, ‘strategy’, ‘conflict’ and ‘change’), national organisational issues (such as ‘star ratings’, ‘Clinical directorate model’ and the private finance initiative, which in the local context is referred to as “Pathway”) and organisational characteristics (‘staff open forums’, ‘UHL managers’ and ‘your role’), which encompassed these five themes. The hypothesis was that using these 23 elements, information could be extracted to analyse doctors’ views on involvement in management.

The *emergent* phrase or word was recorded and participants were then asked also to consider an *implicit* word or phrase, which contrasted to the first word, in a manner which could traditionally be regarded as an opposite or simply as being different in their view to the first phrase. The researcher avoided trying to ‘put

[3] See Appendix C for the full details

words into their mouths', instead choosing to rephrase the concept or theme in a different manner. This approach was repeated for each subsequent interviewee and their explicit and implicit poles recorded[4].

The explicit and implicit poles from the five interviews were then collated into a survey, with the researcher choosing the dominant theme(s) amongst the five to be the explicit or implicit pole for the survey. For example, on the theme of l*eadership*, the five emergent poles were "values you believe in/personal drive", "vision, understanding people, communication", "communicating well, charisma, knowing where you're going", "organisation" and "ability to interact with all people and all levels." The explicit pole chosen for the survey was thus "good communication", although there could be justifiable criticism levied at the researcher for his interpretation of the contrasting poles, thereby allowing an element of bias or presumption to enter the frame here. The researcher aimed to pick a phrase that would capture the dominant essence of what the five interviewers were talking about. This exercise was repeated for each of the 23 *elements*.

The resulting survey was designed to assess clinician perception of their roles and involvement in the management of their area of the hospital. It was sent to 77 consultants drawn from the trust's online telephone directory, equivalent to about 20% of the hospital consultant population.

[4] See Appendix J for a sample of the interview proforma

In order to ensure a representative sample in the data collection, clinicians were grouped according to directorate (starting with A&E and Medicine through to Women's, Perinatal and Sexual Health) and ordered alphabetically. Every fifth name was then selected. Clinicians who had previously been interviewed or those from the Ophthalmology department (in which the researcher worked) were excluded to avoid bias or a conflict in the research. For further information on the organisation and its make-up and the "Pathway" project, please refer to Appendix E.

The survey[5] was sent with an accompanying letter to each clinician, along with a copy of the participant information sheet and research protocol, requesting a response within two weeks[6]. Participants were sent a reply envelope for ease of return. Non-respondents were contacted after this period by telephone and, in some cases, email reminders were sent a further week later to follow up those who had agreed to complete the questionnaire, but who had still not submitted it.

The survey asked each participant to strongly agree, agree or slightly agree with either the explicit or implicit pole, thus offering six choices as demonstrated below:

Element	Emergent Pole	Scale	Implicit Pole
Leadership	Good communication	**1 2 3 4 5 6**	Telling people what to do

[5] See Appendix K for a sample of the survey proforma
[6] See Appendices G-I for the invite to participate letter, participant information sheet and research protocol

If a participant ‘slightly agreed’ that ‘leadership’ was about ‘good communication’, they would circle the number ‘3’ on the above Likert scale. If they ‘strongly agreed’ it was more about ‘telling people what to do’, then they would circle number ‘6’ and so on.

Analysis of Data

There are a number of ways that the data can be analysed, following the application of Repertory Grid, from a simple average of scores, to more specific manual or web-based Repertory Grid techniques of analysis. All offer some form of correlation, which allow both likenesses from the data and interpretations regarding the strength of relationships to be drawn. The results can be seen presented below.

5 consultants were interviewed, all of whom were male. Three were in the age range 55-59, one in the range 45-49 and one in the range 40-44. They had between 21 and 32 years experience as a doctor (with a mean of 28 years), between 10 and 24 years experience as a consultant (with a mean of 17 years) and had been at lead clinician/head of service level or above for between 4 and 13 years (with a mean of 10 years).

Their views ('constructs') on the 23 themes ('elements') led to the creation of a survey ('Repertory Grid'), which was sent to 77 consultants at UHL. One of these was a duplication, an error on behalf of the researcher and was thus excluded from the list. Of the 76 sent, 55 were sent to male consultants and 21 to female consultants.

15 consultants (19%) responded to the survey, of whom 11 were male and 4 female[7]. 17 consultants (22%) declined to take part and 40 (53%) had not responded to either the initial survey or follow-up telephone call. Five surveys (7%) were returned indicating that the consultant had either left the organisation or retired.

The gender of respondents was as follows:

Gender	Surveys sent	Responded to	Declined, not responded, other
Male	55	11 (20%)	44
Female	21	4 (19%)	17
Total	76	15 (20%)	61

Their age range, directorate, length of service and hospital site are indicated in the following tables. Whilst male consultants who responded spanned ages from 35 to 60+, of the four female consultants to reply the age range spanned 50 to 59 years.

Age and gender	Male – responded to	Female – responded to
30-34	0	0
35-39	2	0
40-44	1	0
45-49	4	0
50-54	1	2
55-59	2	2
60+	1	0
Total	11	4

All respondents had been doctors between 13 and 34 years with the average for male consultants of 23 years and for female consultants of 30 years. The

[7] See Appendix F for details of the specialties of the survey respondents

average length of time as a consultant was 13 years for male respondents and 16 for female respondents.

Length of Service (average years)	Male – responded to	Female – responded to
Doctor	23	30
Consultant	13	16
Lead Clinician	5	7

Of the 12 clinical directorates, representatives from eleven were sent surveys, as Clinical Support Services is made up of Allied Health Professional (AHPs) staff. Of the fifteen responses, three (20%) came from A&E and Medicine, 3 (20%) from Anaesthetics, Critical Care and Pain Management, 4 (27%) from the Surgical directorate and the remaining five (33%) from five other directorates. There were no responses from three directorates (Cardio-Respiratory, Children's and Women's, Perinatal and Sexual Health).

Directorate	Surveys sent	Responded to	Declined, not responded, other
A&E and Medicine*	12	3 (25%)	9
Anaes, CC and PM	14	3 (21%)	11
Cancer & Haematology	4	1 (25%)	3
Cardio-Respiratory	7	0 (0%)	7
Children's	5	0 (0%)	5
Imaging	7	1 (14%)	6
Musculo-Skeletal	7	1 (14%)	7
Pathology	5	1 (14%)	4
Renal & Urology	3	1 (14%)	2
Surgical	8	4 (50%)	4
Women's, Perinatal & Sexual Health	4	0 (0%)	4
Total	76	15 (20%)	61

*This includes one consultant who works within the Human Resources (corporate) directorate.

Thirty-five surveys (46%) were sent to consultants at the Leicester Royal Infirmary site, 21 (28%) to Leicester General Hospital consultants and 20 (26%) to Glenfield Hospital consultants. Seven (47%) of the fifteen responses came from LRI, with five (33%) from Leicester General and three (20%) from Glenfield Hospital.

Site	Surveys sent	Responded to	Declined, not responded, other
LRI	35	7	28
LGH	21	5	16
GH	20	3	17
Total	76	15	61

In addition, from the survey responses, a simple *mode* average could be determined. In the table below, the *italics* indicate a preference from respondents towards a particular pole.

	ELEMENTS	**EXPLICIT POLE (= 1 to 3)**	**Mode**	**IMPLICIT POLE (= 4 to 6)**
1	**Leadership**	*Good communication*	2	Telling people what to do
2	**Financial Resources**	*Inadequate and constrained*	2	Is about discipline and creativity
3	**Management-specific education/training for doctors**	*Necessary and highly desirable*	2	Poorly undertaken and inadequate
4	**UHL managers**	Interested (in the service) and successful professionals	5	*Divorced from the "coalface" with a focus on the bottom line*
5	**UHL "top team" i.e. Director level**	Strong, hard working and successful	4	*Not visible and reading the national priorities wrong*
6	**Directorate management**	*"Silo" management*	2	Gets the job done

7	**Management meetings**	*Too many, administrative and tedious*	2	Focussed, effective and democratic
8	**Clinical audit**	*Poorly defined with a "tick-box" approach*	1	Targeted, useful and measurable
9	**Clinical Director role**	Crucial and defines the vision	4	*Necessary to manage other doctors*
10	**Clinical Directorate model**	Gets clinician buy-in	4	*Creates unnatural alliances*
11	**Staff open forums**	*A good concept*	3	Unconvincing, not successful nor well attended
12	**Star ratings**	Have set strategy and improved care	6	*Wrong focus and micromanagement*
13	**Management as a career for doctors**	*Haphazard with no clear progression*	2	Able to make more of a difference
14	**Change**	*A welcome part of everyday work*	2	Is imposed and creates resistance
15	**Management of clinical colleagues**	*Difficult*	3	Enjoyable because they are passionate about what they do
16	**Your role in this organisation**	*Enjoyable, motivating and exciting*	2	Futile, with uncertainty and lack of control
17	**The multi-disciplinary team you're part of, i.e. those you work with on a daily basis**	*Equal and coordinated, with a clear structure*	1	Divergent, egotistical and no clear purpose
18	**Conflict**	*Is about understanding different views*	2	Inevitable, uncomfortable and not easy to deal with
19	**Private practice**	*Personal financial gain*	3	Perverse incentive that creates a differing relationship with patients
20	**"Pathway"**	*Unwieldy, expensive and uncertain*	2	Transform health care in Leicester, in new buildings
21	**Your manager**	*Honest, effective and supportive*	2	Unclear, controlling and remote
22	**Your organisation in three years time**	Redesigned services in a more competitive environment	5	*In transition (a building site) but much the same*
23	**Strategy**	*Centrally (government) driven*	1	Being realistic with the "vision"

This form of average was chosen as it represented the most common value amongst respondents who demonstrated strong preferences in terms of clinical

audit, describing it as “poorly defined with a ‘tick-box’ approach”; the teams they worked with on a daily basis, which were described as equal and coordinated with a clear structure; star ratings, which were deemed to have the wrong focus and be about micromanagement; and strategy, which was seen to be centrally-driven.

Less strong preference was shown for a number of other factors, such as leadership, financial resources and management education for doctors, which were respectively described as being about good communication, inadequate and constrained and necessary and highly desirable. There were slight preferences shown for the remaining five factors, including the role of the clinical director and the clinical directorate model as well as staff open forums, management of clinical colleagues and private practice.

The data was analysed using *WebGrid III*[8], which allowed the researcher to enter the Likert-scale preferences (from 1 to 6 in this case) into a model that produces two key analyses.

The first is known as *principal component analysis*, which positions each element on a map, so that ones which are similar are close to one another. Principal component analysis does involve a mathematical procedure that transforms a number of (possibly) correlated variables into a (smaller) number of uncorrelated

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[8] *WebGrid III* is an internet-based ‘freeware’ programme and can be found at http://tiger.cpsc.ucalgary.ca/

variables called principal components, with the purpose being to identify new meaningful underlying variables.

The second form of analysis allows for a form of cluster analysis to be performed, called *dendritic analysis*, which re-sorts 'elements' and 'constructs' with the aim being to reveal further meanings behind groups of similar data. The idea of revealing the meanings in a Grid by re-sorting it is to place like elements together and like constructs together. Furthermore, alongside the Grid, a set of 'trees' are drawn, which show the strength of any existing correlations.

In this research, dendritic analysis was chosen as the preferred form of analysis, as it loses none of the detail of the relationships between elements and/or constructs, whilst principal component analysis does, although it offers an easier-to-understand visual demonstration of the relationships between elements and constructs.

In 'classic' Grid theory, the results from dendritic analysis can be interpreted and further questions asked of interviewees to verify that two closely-aligned elements actually represent the truth of the situation or not. As this is not possible within the timeframe of this research, it will instead allow recommendations to be made for further areas of interest to be explored.

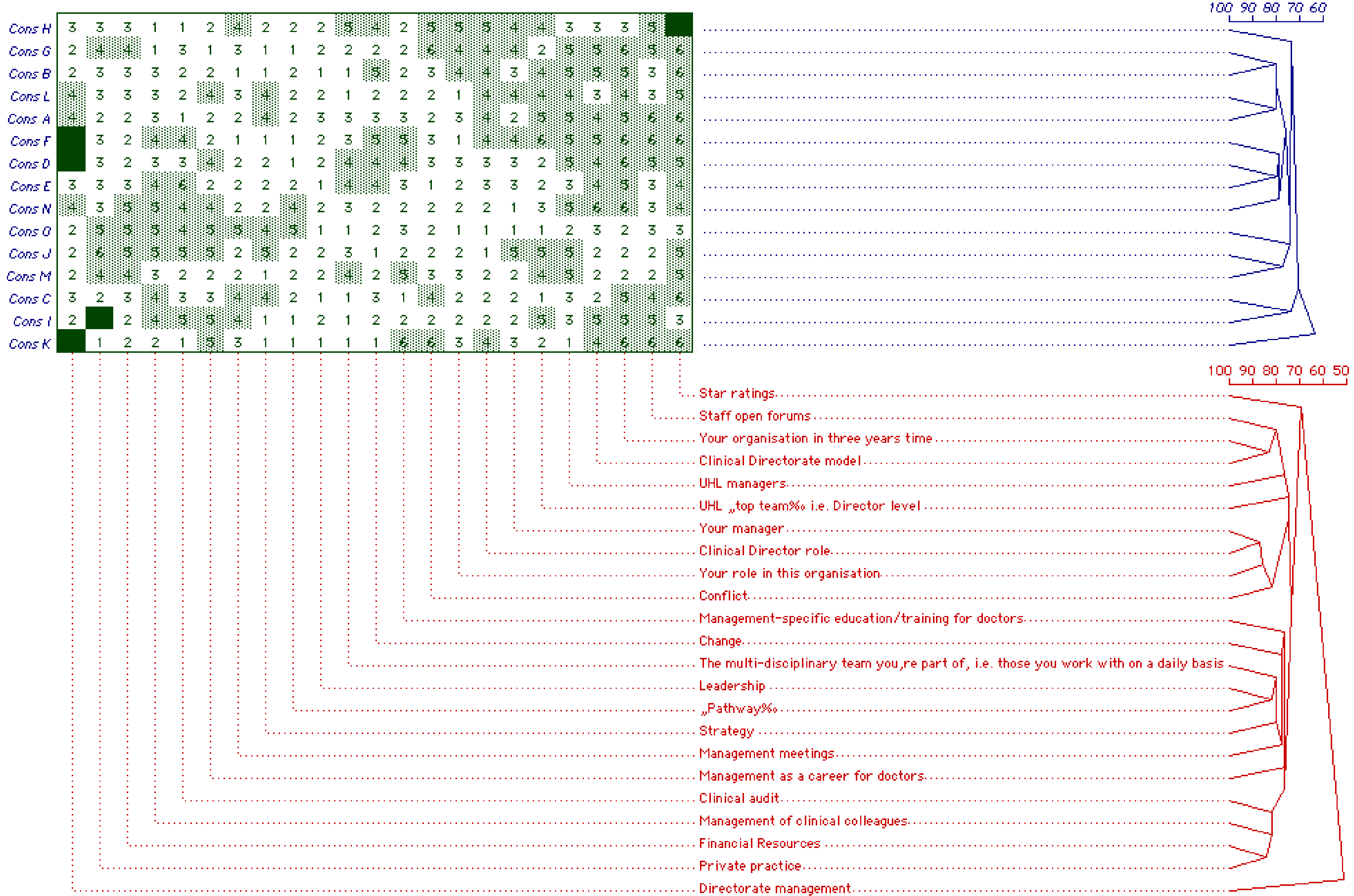
37 pairs of elements showed a correlation of .76 or higher but eight pairs had a higher correlation of above .80 between the elements. These are also shown

below. Three elements did not show a correlation with any other element of greater than .76: these were E5 (UHL top team), E6 (Directorate management) and E12 (Star ratings).

***WebGrid III* Element Correlation**

Corr.	Element	Element
.87	E9 (Clinical Director role)	E21 (your manager)
.85	E9 (Clinical Director role)	E16 (Your role in this organisation)
.84	E2 (Financial resources)	E19 (Private practice)
.83	E10 (Clinical directorate model)	E22 (Your organisation in 3 years time)
.81	E1 (Leadership)	E20 (“Pathway”)
.81	E2 (Financial resources)	E15 (Management of clinical colleagues)
.81	E8 (Clinical audit)	E15 (Management of clinical colleagues)
.81	E16 (Your role in this organisation)	E18 (Conflict)
.80	E1 (Leadership)	E17 (The MDT you’re part of)
.80	E9 (Clinical Director role)	E14 (Change)
.80	E11 (Staff open forums)	E22 (Your organisation in 3 years time)
.80	E16 (Your role in this organisation)	E21 (Your manager)
.80	E20 (“Pathway”)	E23 (Strategy)
.79	E10 (Clinical directorate model)	E11 (Staff open forums)
.79	E1 (Leadership)	E16 (Your role in this organisation)
.79	E7 (Management meetings)	E20 (“Pathway”)
.79	E13 (Management as a career)	E15 (Management of clinical colleagues)
.77	E1 (Leadership)	E23 (Strategy)
.77	E2 (Financial resources)	E21 (your manager)
.77	E7 (Management meetings)	E23 (Strategy)
.77	E9 (Clinical Director role)	E18 (Conflict)
.77	E14 (Change)	E17 (The MDT you’re part of)
.77	E16 (Your role in this organisation)	E17 (The MDT you’re part of)
.76	E1 (Leadership)	E3 (Management-specific education)
.76	E1 (Leadership)	E7 (Management meetings)
.76	E1 (Leadership)	E14 (Change)
.76	E2 (Financial resources)	E7 (Management meetings)
.76	E2 (Financial resources)	E13 (Management as a career)
.76	E2 (Financial resources)	E20 (“Pathway”)
.76	E3 (Management-specific education)	E14 (Change)
.76	E4 (UHL managers)	E10 (Clinical directorate model)
.76	E7 (Management meetings)	E13 (Management as a career)
.76	E7 (Management meetings)	E16 (Your role in this organisation)
.76	E8 (Clinical audit)	E13 (Management as a career)
.76	E9 (Clinical Director role)	E10 (Clinical directorate model)
.76	E13 (Management as a career)	E20 (“Pathway”)
.76	E14 (Change)	E16 (Your role in this organisation)

FOCUS Domain:
Context: , 23 Elements, 15 Constructs



***WebGrid III* Clustering**

Discussion of Results

In coming to any conclusions about this research and the use of the Repertory Grid technique, the author is reminded of what Dr Valerie Stewart[9], an experienced user of Repertory Grid Theory, has said:

> "For many purposes, especially the 'reflective' uses of Grid, the journey matters more than the arrival: meaning that the insights garnered in the course of eliciting elements, constructs …and looking at the analysis so far may be much more useful than the final presentation of the data by your chosen methodology."

This statement cautions the author and readers alike to be aware of drawing conclusions in analysis based merely on scores and correlations. It therefore allows this research to consider a wider context of quantitative and qualitative evidence regarding doctors' involvement in NHS management from which the conclusions and recommendations are drawn.

Skills and standards

On the issue of skills and standards, interview respondents felt management-specific education and training for doctors to be very necessary, essential and highly desirable, of real benefit and effort and integral to learning. There was concern that insufficient time was given to this and that resources, which were inadequate for the purpose, may be targeted at the wrong people. In addition, there was a concern that there may be those who were simply not interested in

[9] Dr Valerie Stewart is a consultant industrial psychologist and renowned expert on the use of Repertory Grid Theory, whose website www.EnquireWithin.co.nz offers a multitude of tips, hints and information on the use of Repertory Grid Techniques.

undertaking any training or if they did it was seen to be poorly undertaken. Survey respondents were also of the view that management-specific education was necessary and highly desirable, which is supported by the literature (Dopson 1994, Horsley 1996, Austin and Dopson 1997, Hopkinson 2000).

In terms of leadership, three of the five interviewees believed that leadership was about communication, as well as organising, planning and motivating and enabling people to fulfil their roles within the organisation. There was a feeling that leadership could be about telling people what to do and ploughing one's own furrow, as well as about having preconceived ideas, which makes the case for development of interpersonal and communication skills (as outlined by Sutherst and Glascott 1993, Gatrell and White 1996,) even more important.

Perkins (2004a) reports a Repertory Grid study carried out in New Zealand's health sector in 2002, amongst senior manager and clinicians, focussing on the factors relating to effective leadership. They identified that listening and communicating, encouraging and facilitating, having a vision that they shared and being goal oriented and getting things done were the key factors to bring about effective leadership. As with participants in this study, communication was seen to be a key aspect of leadership.

In addition, a high correlation (.81) was found between leadership and "Pathway", with those viewing good communication as crucial to leadership also viewing "Pathway" as unwieldy, expensive and uncertain. It is certainly true that to deliver "Pathway", there will be a need to effectively communicate its purpose and 'explain away' any uncertainty and unwieldiness.

A further means of understanding the skills required for doctors was to seek their views on something that was recognisable to them all, but whose impact was little understood. Clinical audit is vaunted as a robust means of understanding current practice and in this study there was the view that it was the key to good risk management and assessment, and could be important and useful if carried out well, in instances where it draws comparisons within or outside the organisation.

However, the overwhelming feeling of interviewees was that, in UHL, this had no focus and only came out of an individual's curiosity, rather than being set against any national benchmark. It was felt that the trust didn't get its money's worth out of clinical audit and didn't target the 'problem' areas, saying it was poorly-defined and adopted a 'tick-box' approach.

A high correlation (.81) was also found between this element and management of clinical colleagues and an inference could be drawn from the survey that where clinical audit was poorly undertaken and carried out in a non-controversial, tick-box manner, this was because a senior clinician would have been expected to tackle the clinical practice of a colleague and failed to focus on useful and measurable aspects to avoid any difficulties in managing them.

Interest and career

Many doctors seemed willing to commit time to management and ten out of the fifteen respondents were or had been involved in management in a formal way,

either as a clinical director or equivalent for their specialty. On average, respondents had over five years experience in this role. However, as supported by the literature, there was the view that management as a career for doctors was haphazard with no clear progression (Fitzgerald 1994, Austin and Dopson 1997) and interviewees felt that management could only ever be at most a part-time career and was less credible the further the clinician strayed from clinical work. Although there was a belief from one interviewee that he could do more good to more people in a management role, others felt that they, as doctors, wouldn't make good managers, but could instead become good leaders and strategists. This distinction between leadership and management is one of the most crucial in terms of realising the appropriate role doctors should play in the future 'management agenda' of the health service.

In terms of how consultants viewed their role in the organisation, this was felt to be fun, changing, rewarding and evolving when asked of the interviewees, although there was an acceptance of it being uncertain, futile and powerless at times. There was also a feeling of futility in what they were trying to do, but it was generally agreed that it was enjoyable, motivating and exciting, something which Buchanan et al. 1997 found in their study. Again a correlation of .85 between how doctors perceived their own roles and that of the clinical director, would suggest that clinical directors, as the senior 'doctor-managers' in the organisation, have a huge bearing on the roles 'ordinary' doctors play. As the people who define the vision and set the strategy, they are largely responsible for the way in which doctors carry out their roles in UHL.

A further correlation was found between individual's perception of their roles and conflict (.81), but not as may be expected from the literature. In what could be considered a surprising finding, the general feeling was that consultants enjoyed their roles in the organisation and the same consultants viewed conflict in terms of a need for better understanding of different views. This would seemingly make most UHL consultants quite enlightened in contrast to other more traditional members of the profession, although such an element did exist within UHL who felt both futility in their role and unease when confronted by conflict.

Role pressure/time

Change was also viewed as a "welcome part of everyday life", more so than being something that was imposed and resisted by consultants. However, the view that change occurred because of political expediency was also mentioned (again supported by the literature – for example the work of Ong et al. 1997), which did mean that there was some element of resistance to change and difficulties in getting people 'on board'.

Consultants also felt their own managers, most likely to be clinical directors or other heads of service, to be honest, effective and supportive of their roles. They were also perceived to be both helpful and easy to get on with, although their role was made more difficult to do because some managers were stifling, remote, negative and sometimes not clear about what needed to be done.

UHL's directorate management structure didn't fare much better. This 'element' aimed to find out how participants felt the specific directorate in which they

worked operated. Consultants were ill at ease with its ‘silo’ approach, which implies there was little working across the organisation to solve individual issues, although there was unfamiliarity with this term, which meant that it was the question that was least responded to. Interviewees tended to give much more general answers to this, as they were at the top of the organisation and not necessarily aligned to a specific directorate. Comments such as ‘ineffectual, with no clear direction’ and ‘not fully integrated’ were made by interviewees, although the alternative view was very much that directorate management got the work done and offered the organisation clear accountability and responsibility.

Clinical conflict

Management of clinical colleagues was viewed by respondents as difficult and by one interviewee as “scary”, which is again substantiated by the literature (Fitzgerald 1994) but conflict was also viewed in terms of understanding the different views of colleagues, describing it as interesting, enjoyable and challenging, although there was a real sense that this management had to be done “without them feeling managed”, because they weren’t fully engaged in the management agenda.

Linked to this issue is the conflict that sometimes arises out of managing peers. This was viewed in terms of resolution and negotiation, with one interviewee describing it as the ‘beginning of an understanding’*.* There was an acceptance of its inevitability and that conflict shouldn’t be ducked but should only be entered into “when absolutely sure of one’s facts.” There was a correlation of .81 between those who felt managing their colleagues was difficult and also felt that money

was constrained. Often the tensions that arise from dealing with colleagues, and this is a true experience within UHL, come from having to explain that no more resource is forthcoming and that despite logic dictating otherwise, the NHS doesn't run like a business (although the formative introduction of the financial flows agenda could be about to change that).

Consultants felt that strategy was driven centrally by the government, which is also supported by previous research (McClelland and Jones 1997, Curley et al. 2002). It was also felt that this strategy was not communicated well and was unrealistic. Taking star ratings as an example of such centrally set strategy, this can be seen as one way in which the government can measure improvement in hospitals. Indeed there was support for them in the sense that they had helped set national strategy and made the organisation face its issues, improving certain aspects of care, such as emergency department waits, with one interviewee going as far as to describe star ratings as " brilliant, fantastic and culture transforming." However, also within this study, there was a strong view that these had the wrong focus and were an example of micromanagement by the centre, which consultants felt reflected the nature of centrally set strategy.

Overall, the issue of private practice didn't seem to energise participants as much as the literature would suggest. The overwhelming feeling with regard to private practice was that it was evidently about personal gain, and as long as a consultant fulfilled their NHS commitment, there wasn't a problem with it, although where it did conflict with this work, it was a cause of concern and a couple of interviewees mentioned the perverse incentive it could create. Others viewed it as a good use of doctors' skills and passions. A correlation of .84 was

found between financial resources and private practice and it is interesting to see that respondents who saw the former in terms of a lack of resource also viewed private practice in terms of personal financial gain, whilst those who viewed finances in terms of 'creativity and discipline' also saw the potential for a perverse incentive in private practice. It would be intriguing to explore this relationship further to establish whether the freedom of private practice to gain financially means that the attitude of consultants is so set towards viewing the NHS as forever cash-constrained and under funded.

In terms of more specific local issues, consultants viewed UHL managers and UHL's 'top team' of directors in a negative mindset. The former were described as being 'divorced from the coalface', with a preoccupation on the financial bottom line and spending insufficient time understanding the clinical view, whilst the latter were accused of not being visible and of reading the national priorities wrong. Both of these views can be seen in a similar vein to research by Walker and Morgan (1996), Buchanan et al. (1997), Ong et al. (1997) and Sutherland and Dawson (1998).

However, there were pockets of support, with some interviewees describing both groups as successful because the organisation had received three stars in the most recent rating of the hospital. In addition, the 'top team' were also described as strong, despite the fact they would "beat around the bush over key issues." This view suggests that there was the same distinction as described by Chantler (1999) between those at the top of the organisation setting the direction and others within it.

Resource management and organisation

In terms of resources, the emergent views from the interviewees regarding finances were that they were set at challengeable limits, required discipline and creativity, as well as realism in what they can be used to achieve. There was the view that they were the “enabler for what we want to do,” although this differed from the majority of survey respondents who viewed finances as inadequate and constrained, which is supported in the literature (Dopson 1994, Simpson 2000 and Hopkinson 2000).

Although the literature bears out the view that the clinical directorate model is a way of involving clinicians through decentralisation and delegation of responsibility and authority (Willcocks 1997, Austin and Dopson 1997), respondents in this study felt that it created unnatural alliances between clinical specialties, rather than achieving its aim of clinician buy-in. However, where the literature was supported, the clinical directorate model was described as “important in terms of achieving what the organisation needed”, but there was a feeling that it produced generic workers with no sense of belonging or identity. Those who felt the clinical directorate model created unnatural alliances also viewed the organisation to be in transition (with a correlation of .83), which could suppose the need for a change in structure. Those who felt it was managed to involve clinicians felt that the organisation would be in a more competitive field in the near future. It is not evident that any real conclusion can be drawn from that, although it may suggest that a change in structure could be required if the organisation was to benefit fully from the financial freedoms of the new NHS.

Anecdotally, management meetings are considered the bane of every clinician's working day and interviewees in this study felt that there were too many, they were administrative and tedious. They were described as a necessary evil, with too many of them and too many people involved. However, as with the clinical directorate model, there was a feeling they were a way of delivering the trust agenda and included and empowered stakeholders within the organisation, despite the perceived lack of decision-making authority.

In UHL, the role of the clinical director was viewed as being crucial in terms of defining the vision of the directorate and for carrying out important tasks such as consultant appraisal and negotiating the consultant contract. The highest correlation in the study (.87) was found between the role of the clinical director and that of respondent's managers, which is not unsurprising as often most consultants are formally managed by a clinical director or equivalent. In larger directorates, post holders were perceived to have an 'undoable' job, despite having delegated authority for budgets of around £50m. Similarly, the evidence from this study supported earlier findings that often the role relieved boredom and represented a 'curiosity thing' for some clinical directors, whilst others were just seeing out time to retirement. One view questioned why the role had to be held by a doctor, which endorses Griffiths' original view that the role could be held by other professionals such as nurses.

In this survey participants were positive about the teams they worked with on a daily basis, which contrasts the view held in the literature (McDermott et al. 2002) that consultants had failed to get to grips with team-based working and their role as part of it rather than being the leader. However, some were described as

‘woolly and vague’ with tension and divergent views, which implied that there was a need for much more agreement and consensus on the direction of the team and its aims.

In UHL, as in many NHS organisations, structures for communicating information often take the form of open meetings or briefings for staff. On a monthly basis, the Chief Executive of the organisation holds such a briefing session to cascade information to staff, held on a rotating basis on each of the three hospital sites and broadcast simultaneously to the other two.

It was felt that these provided an opportunity for open praise and allowed the Chief Executive to be visible, whilst making staff feel included and important. The levels of attendance and subsequent effectiveness as a means for communication were questioned, with may be only a few hundred out of the organisation’s ten thousand staff attending and likewise, the stage-managed, lecture style of the event meant that these forums were often viewed as unconvincing. However, the Trust has taken measures since the forum’s inception to further engage staff members with the organisation’s aims and developments by making the information available on its intranet in an attempt to widen its exposure.

Further local context was explored through gaining views on the organisation in three years time and the “Pathway” privately financed building programme.

With the preferred bidder having been chosen since this research was conducted, it now places UHL in the much more certain situation where, in three

years time, the organisation will be in the midst of Pathway. In addition, and assuming the organisation maintains its three star rating, it could well be a Foundation Trust. Interviewees therefore felt their organisation would be very different, with redesigned services and ‘about as bad as it gets’ in terms of working on a building site. The acknowledgement of the financial flows agenda (‘payment by results’) was also recognised with the acceptance by consultants that they would be working in a more competitive environment.

Pathway itself was mainly considered to be about “new buildings”, but it was also deemed “essential” and a “better solution to what we’ve got”, transforming Leicester and in the view of one interviewee “counteracting forty years of underinvestment”. It was equally regarded as huge, bureaucratic, unwieldy, expensive and uncertain, with concerns that the project won’t deliver what a lot of people want and expect it to.

Therefore, the near future of the organisation, much like its infrastructure, could be seen to be dominated by Pathway. Despite this, surprisingly to some, it was also felt that the organisation would be much the same as it was currently.

Conclusions and Recommendations

This research confirms many of the findings of previous research, but ten or so years on from a great deal of the literature, it still offers an insight into the thoughts of modern-day consultants with regard to their involvement in management.

Many consultants supported views about management borne out by the literature and it was evident that the five thematic areas, as outlined in the methodology, did emerge where doctors' involving in management seemed to be concentrated. The same can be said of survey respondents, who, in answer to the poles set by the interviewees, provided a good snapshot of clinician involvement in management.

However, based on the above evidence, a number of key recommendations can be derived.

1. A number of authors (Gatrell and White, Buchanan et al) have already laid out the key areas where efforts regarding training and development for doctors could be focussed. Respondents to this research also 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. UHL managers should be more involved in understanding what their 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. UHL's top-team should do likewise. 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. There should be some forum established for crosscutting directorate issues to be shared openly and worked on collaboratively. Its agenda should be focussed on what can be effectively delivered and should involve all relevant stakeholders.

4. More national benchmarking in terms of audit should be done and any concerns about individual practice need to be confronted objectively and openly by senior clinicians and managers.

5. 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. UHL should review its structure for delivering this.

6. It is difficult to recommend any changes to the way performance is measured or strategy is set, as that is outside the control of any NHS organisation, but government should take notice of the strength of feeling that is emanating with regard to performance measures and the setting of strategy. However, the method of communicating that performance or strategy is within the power of the organisation.

7. In classic Repertory Grid theory, the results of the dendritic analysis are often reviewed by the original participants to verify the correlations of paired elements. This would add another level of depth to the interpretation of the results and also help to discard any matches that were not intended or implied.

8. A way of gathering more clinician views regarding their involvement in management should be attempted, either via a survey or further research building upon this approach and to the same target group in three years time. This would enable comparisons to be made between the results of 2005 and 2008 and see whether the same degree of satisfaction and / or frustration still exists. It would enable UHL to involve its clinician population (and could include all levels of clinicians) in the management agenda of the organisation by listening to and taking on board their views regarding their interests and skills, training and development and views on the structure of the organisation.

The issue of involving clinicians in management should arguably be just the first step in providing the highest quality care for the maximum health gain for a local

population, within the resources allocated across the UK. Indeed, there is a need for better accountability and decision-making, audit in clinical care and processes, empowerment of all staff and improvements in the information to make any crucial decisions.

An excellent example of taking the issue of clinician involvement in management seriously has come in the form of the Clinician in Management initiative in Ireland (see Appendix B for more information). Such a programme was formalised and led to the involvement of clinicians in the Irish national health strategy ("Quality and Fairness: a Health System for You"), thus demonstrating that it is possible to work with clinicians in realising the management agenda.

If the above recommendations and a blueprint as realised in Ireland can be achieved, then a debate about the use of resources in health care can move to the next level. It is time the UK government and health organisations up and down the country adopted such an approach to benefit patients and all staff alike.

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APPENDIX A

A FRAMEWORK FOR CLINICIAN TRAINING AND DEVELOPMENT

Gatrell and White (1996) narrowed down the areas where doctors could receive training to five broad clusters of capabilities:

- Interpersonal skills;
- Contextual awareness, defined as "the understanding and ability to operate effectively at all levels in the context of NHS organisational structures."
- Strategic thinking, based on an understanding of strategic processes and the ability to apply them;
- Functional and operational skills and knowledge, a range of activities and processes generally associated with the daily operation of units in healthcare organisations;
- Self-management.

Buchanan et al (1997) also established five factors:

- The perspective factor, which concerned the ability to bring an understanding of clinical issues to hospital decision making;
- The patient factor, the ability to adopt a patient-oriented approach in discussions and decisions;
- The credibility factor, the importance of clinical knowledge and experience in representing clinical colleagues and in carrying them in critical decisions;
- The skills factor, which refers to the observation that doctors are already highly educated and have analytical, diagnostic, decision-making skills, which they apply every day to issues of a clinical focus.
- The network factor, which refers to the involvement of senior clinicians in professional organisations and societies, the extent to which this broadens system understanding and awareness of wider clinical and political issues.

APPENDIX B

THE CLINCIAN IN MANAGEMENT INITIATIVE

The "Clinicians in Management" (CIM) initiative, launched in Ireland in 1998, sponsored and facilitated by the Office for Health Management, has been an example of a concerted effort by politicians, managers, academics and clinicians to "provide for balanced decision-making between doctors, nurses and allied health professionals, and to decentralise the responsibility for managing resources down to local units with their direct participation." (OHM 2000 p.1) Many of its ideas are not new to UK health care, but the CIM programme has shown that a coordinated and structured approach can be taken. In addition, this programme led the Irish national health strategy of 2001 ("Quality and Fairness: A Health System for You") to highlight the key role clinicians can play in the planning and delivery of a top quality, patient-centred health service.

According to the CIM (OHM 2003 p.11-12), organisations can help facilitate doctors' participation in leadership roles by:

- Walking the talk – managers trusting their medical colleagues
- Choosing a structure that suits the organisation
- Clarifying what clinical leaders' roles and responsibilities are
- Giving doctors real decision-making power
- Eliminating some layers of administration
- Devolving authority to allow maximum decision-making at local level
- Demonstrating that experience of clinical leadership is valuable for career advancement
- Providing a career path
- Acknowledging and minimising as much as possible the costs involved for doctors
- Providing training and development that [a] is unidisciplinary, [b] incorporates an action learning approach, [c] delivers knowledge of management terminology, [d] demonstrates how the system works nationally and internationally, [e] offers insight into leadership strengths and weaknesses, [f] incorporates training in time and change management and [g] provides opportunities for networking with other clinical leaders and management.

APPENDIX C

ELEMENTS

1. Leadership
2. Financial Resources
3. Management-specific education/training for doctors
4. UHL managers
5. UHL “top team” i.e. Director level
6. Directorate management
7. Management meetings
8. Clinical audit
9. Clinical Director role
10. Clinical Directorate model
11. Staff open forums
12. Star ratings
13. Management as a career for doctors
14. Change
15. Management of clinical colleagues
16. Your role in this organisation
17. The multi-disciplinary team you’re part of, i.e. those you work with on a daily basis
18. Conflict
19. Private practice
20. “Pathway”
21. Your manager
22. Your organisation in three years time
23. Strategy

APPENDIX D

RESEARCH AREAS

The researcher was able to find forty questions regularly emerging from the literature that have been used in the past to ask doctors about their involvement in management. These naturally fall into five thematic groups. The questions and their groupings are outlined below. Out of these questions came the 23 'elements' used in the Repertory Grid interviews. The forty questions would fit well into a traditional questionnaire but this research model was keen to eliminate as much bias as possible from the process and instead allow doctors the freedom to express, in their own words, their views on management. The 23 elements that were chosen were relevant to the local environment of the study and consultants would have been aware of their existence.

SKILLS and STANDARDS

1 - Can a doctor be a strategist / influencer?
2 – What is the value of professional management standards?
7 - Would you like management training to be a part of your job?
10 - What particular skills would be of value? E.g. finance, HR, communications, time management, conflict management, change management, contextual awareness?
13 – Is involvement in management 'de-professionalising'?
16 - What are your views on leadership? What does it take to be a leader?
19 - Are doctors' natural managers?
28 - Would you have benefited from some management training / development at medical school, given what you know and experience now?
34 - What benefits do you think a clinical education can bring to the process of management and delivering health care services?
40 - What do you consider to be the key factors in creating a successful management role / being a successful manager?

INTEREST and CAREER

3 - Can management ever be a career for doctors?
4 – What is your approach or feeling towards innovation (as expressed by Rogers (1962) innovator to laggard model)?
5 - What is the biggest influence on your willingness and ability to get involved in management?
6 - What areas of management would you like to be involved in?
14 - What new challenges are you seeking in your career?
15 - Can management be "credible" to doctors?
22 - Could doctors simply be very expensive and inexperienced managers?
25 - Can you explain why so many doctors think it is important doctors are involved in management; yet report no personal involvement themselves?
30 - What would you say is the single most important reason for involving doctors in management?
35 - What are your main sources of satisfaction and dissatisfaction in your role?
36 - What advice would you offer about management in the NHS to a doctor about to become a consultant?

38 - Is a management role a “career break” or rather a stepping-stone for the future?

ROLE PRESSURE / TIME

8 - Are you put off actively involving yourself in management in the NHS because it will impinge on clinical activities within as well as outside the NHS?
9 – Does involvement in management create ‘role overload’?

(CLINICAL) CONFLICT

11 - Is your involvement in management eroding your clinical autonomy / authority?
17 - Do you fear being managed and does that influence whether you get involved in management activities or not?
18 - What is your opinion of current non-medical managers and their ability to run the NHS?
21 - Should managers be able to challenge the decision making of doctors?
23 - Would you rather maintain clinical credibility as a consultant at the expense of achieving success as a manager of clinical resources?
26 - Do you fear being alienated from your peers by involving yourself in management activities?
27 - If doctors were to become more involved in management, do you think there would be reluctance amongst non-medical managers to let go of responsibility?
32 - Do you accept there is a managerial / management responsibility that accompanies your clinical freedom?
33 - Do you think the interests and priorities of managers and doctors are in conflict?
39 - Do you think clinical managers can ever effectively line manage their clinical colleagues?

RESOURCE MANAGEMENT and ORGANISATION

12 – Is your clinical decision-making ever influenced by rationing / economic constraints?
20 - What is the perception of your role and responsibility with regard to the management of resources?
24 - Is involving doctors in management an efficient and effective way of using resources?
29 - How relevant do you see the economic and practical constraints of the NHS in your every day decision-making?
31 - Do you see managers as part of the multi-disciplinary team that helps to deliver health care?
37 - How do you think your clinical directorate / department should be organised?

APPENDIX E

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST (www.uhl-tr.nhs.uk)

University Hospitals of Leicester NHS Trust (UHL) is one of the largest and busiest teaching Trusts in England, employing over 11,000 staff and providing services to nearly a million people across Leicester, Leicestershire and Rutland. It has an annual income of £460 million. The Trust was formed on 1 April 2000, following the merger of Glenfield Hospital, Leicester General Hospital and Leicester Royal Infirmary. All three hospitals provide acute general hospital services to the people of Leicester, Leicestershire and Rutland.

The Trust also provides high-quality specialist care, including cardiovascular, cancer, fertility and renal services to patients across the country, with many being referred by other hospital consultants. Locally, the Trust serves, in partnership with 6 Primary Care Trusts, a diverse area of contrast, with some of the poorest communities in the country alongside some of the wealthiest. In 2000, the Trust embarked on the *Pathway* project, a private-finance initiative plan to reconfigure acute services in Leicester, Leicestershire and Rutland.

There are 12 Clinical and 10 Corporate directorates within UHL, as listed below.

Clinical

1. A&E and Medicine Services
2. Anaesthetics, Critical Care & Pain Management
3. Cancer & Haematology Services
4. Cardiology Respiratory Services
5. Children's Services
6. Clinical Support Services (includes Disablement Services Centre, Medical Illustration, Medical Psychology, Neuro Psychology, Nutrition and Dietetics, Occupational Therapy, Orthotics, Pharmacy Department, Phlebotomy, Physiotherapy Department, Podiatry, Speech and Language Therapy)
7. Imaging
8. Musculo-Skeletal Services
9. Pathology Services
10. Renal Services & Urology
11. Surgical Services
12. Women’s, Perinatal & Sexual Health Services

Corporate

1. Clinical Governance
2. Corporate & Legal Affairs
3. Facilities
4. Finance
5. Human Resources
6. Information Management & Technology
7. Nursing
8. Operations
9. Research & Development
10. Strategic Development

THE “PATHWAY” PROJECT

The Pathway project is a £761million, five-year plan to extensively reconfigure and develop the three hospitals in Leicester (Glenfield, Leicester General and Leicester Royal Infirmary).

The project is the largest PFI hospital development outside of London and the most ambitious in the country to date. It will give Leicestershire some of the best hospital facilities in the country, including:

- The largest maternity service in Western Europe on one site
- A landmark children’s hospital
- A dedicated planned care and rehabilitation hospital
- Smaller wards (reduced from 32 beds to 24) to improve patient care
- A reduction in the size of ward bays (accommodating four beds instead of six)
- Providing an average of 33% of all patient beds in single rooms based on clinical need
- Increased distance between beds improving infection control and increasing patient privacy
- Better hand washing facilities and domestic services
- Flexibility to increase bed capacity
- State-of-the-art clinical research centre
- Emergency and planned care split, reducing the risk of cancelled operations
- Multi-Professional Education & Training (MPET) Centre to be developed in partnership with De Montfort University and the University of Leicester Medical School to provide innovative shared multi-professional teaching and clinical skills education and training
- Multi-storey car park at Leicester Royal Infirmary

Pathway will also greatly enhance Leicester’s health education, training and research facilities in Partnership with the University of Leicester and De Montfort University.

APPENDIX F

SURVEY RESPONDENTS

A	Consultant Dermatologist
B	Consultant Neurologist
C	Consultant Occupational Physician
D	Consultant Anaesthetist
E	Consultant Anaesthetist
F	Consultant Anaesthetist
G	Consultant Histopathologist
H	Consultant, Surgical Directorate
I	Consultant Surgeon
J	Consultant Vascular Surgeon
K	Consultant Surgeon
L	Consultant Oncologist
M	Consultant Radiologist
N	Consultant Orthopaedic Surgeon
O	Consultant, Renal & Urology

APPENDIX G

INVITATION TO PARTICIPATE LETTER

Name
Address

Dear

RE: Involving doctors in management research study

I am carrying out a research study at the three hospital sites of the University Hospitals of Leicester (UHL) NHS Trust as part of my Masters of Science in Health Care Management at the University of Birmingham.

The study is designed to examine the involvement of doctors in management and to determine why doctors become involved in non-clinical issues that are often deemed the responsibility of NHS managers and administrators. The study is to last four months from November 2004 until February 2005.

I have already interviewed five current NHS consultants within UHL, currently involved in management, to find out their views on this research subject. By carrying out this research I will be looking to find further reasons to understand why doctors would wish to become involved in non-clinical issues that underpin the running of the NHS. The interviews have formed the basis of the attached survey that I am sending to thirty further NHS consultants employed at UHL to provide some quantitative evidence to support the research question.

If you would like to take part in this study, please complete the reply slip, consent form and the attached survey and return it to me in the enclosed envelope by …………... If you decide not to take part in this research study and choose not to answer the survey, could you please return the reply slip indicating that?

I would like to thank you for taking time to read this letter and hope to hear from you soon. If you have any queries, please feel free to contact me on the telephone number below.

Yours sincerely,

Simon Moralee
Service Manager
Ophthalmology

Extension 5929

APPENDIX H

PARTICIPANT INFORMATION SHEET

You are being invited to take part in this research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

The study is designed to examine the involvement of doctors in management and to determine why doctors become involved in non-clinical issues that are often deemed the responsibility of NHS managers and administrators. The study is to last four months from November 2004 until February 2005.

The issue of involving clinicians in management has been on the agenda of the NHS since the 1970s. As clinicians are the key determiners of health care resource use by way of their clinical decisions, their engagement is deemed vital in terms of cost effectively using resources and deciding where resources should be directed, as well as containing ever-growing costs.

In the current, traditional hierarchy amongst clinicians, doctors are the key group of decision makers in the NHS. They make the most important clinical decisions on behalf of, and with, their patients and their vital knowledge of the technologies and skills available to treat patients means they are ideally placed to understand the implications of their decisions for the whole health service. However, it seems there has been some reticence amongst clinicians to become involved in what are often seen to be "administrative" duties over the past 30 years, preferring to stay in the clinic room and operating theatre, rather than the seminar and board room.

This research is vital in continuing to understand why some doctors become involved in management and what motivates them to do so, whilst others choose not to.

It is up to you to decide whether or not to take part in this study. If you do decide to take part, please keep this information sheet and sign the attached reply slip and consent form. Please then answer the survey as indicated and return it to me. If you decide to take part you are still free to withdraw at any time and without giving a reason. Your involvement in this study will be kept confidential to me as the principal investigator and will not be released to any other party.

The research is being funded by the Surgical Services Directorate at UHL. The results of the study will be published in my Masters thesis, available at the University of Birmingham and at UHL.

Version: 1.1

Date: 21 January 2005

APPENDIX I

RESEARCH PROTOCOL

MSc Health Care Management (University of Birmingham, 2004-05)

"An Investigation into the reasons why doctors become involved in management and what motivates them to become involved in the NHS management agenda."

Simon Moralee BA (Hons) MSc Pg. Cert. Pg. Dip. MCIM MIHM
Service Manager
Department of Ophthalmology
University Hospitals of Leicester NHS Trust
Leicester Royal Infirmary
Leicester
LE1 5WW

Summary of research:

This research aims to determine why doctors become involved in non-clinical issues that are often deemed the responsibility of NHS managers and administrators. At present, there is a small, but growing, literature which has investigated this topic, but there is still much to find out about what motivates doctors to get involved in the management and government agenda. By carrying out this research I will be looking to find further reasons to understand why doctors would wish to become involved in non-clinical issues that underpin the running of the NHS. This research aims to find new reasons and explanations for why doctors are motivated to extend their involvement in health care beyond their clinical day-to-day responsibilities.

Introduction:

The issue of involving clinicians in management has been on the agenda of the NHS since the 1970s. The Griffiths Report (1983) was perhaps the most obvious attempt at creating a management agenda for health care and the Harvard Clinical Directorate model was adopted in the late 1980s by Guy's and St.Thomas' Hospital in London as a way of involving doctors in this process. As clinicians are the key determiners of health care resource use by way of their clinical decisions, their engagement is deemed vital in terms of cost effectively using resources and deciding where resources should be directed, as well as containing ever-growing costs.

In the current, traditional hierarchy amongst clinicians, doctors are the key group of decision makers in the NHS. They make the most important clinical decisions on behalf of, and with, their patients and their vital knowledge of the technologies and skills available to treat patients means they are ideally placed to understand the implications of their decisions for the whole health service. However, it seems there has been some reticence amongst clinicians to become involved in what are often seen to be "administrative" duties over the past 30 years, preferring to stay in the clinic room and operating theatre, rather than the seminar and boardroom.

This research is vital in continuing to understand why some doctors become involved in management and what motivates them to do so, whilst others choose not to.

Population to be studied:

NHS Consultants

Recruitment/Inclusion/Exclusion criteria:

The only inclusion criteria are that the individuals must be an NHS consultant working at the University Hospitals of Leicester NHS Trust and be willing to be interviewed. There are no exclusion criteria based on age, gender, race, age, social condition, sexual preference. The only exclusion criterion is that consultants who do not work at UHL will be excluded.

I will discuss with the Clinical Director and General Manager of my directorate which individuals I think would provide me with a broad sample of views and opinions so as to increase the validity, credibility and applicability of this research and its findings. It is likely that I will ask those who have taken an active role in non-medical tasks to be interviewed, as they are most likely to help answer the research question.

I will then write to the 4-5 interviewees explaining the purpose of the research and what I would want to achieve in the interview and seek their agreement and permission to continue. I will do this until I have identified at least 4 willing individuals. I intend to interview these participants for no more than 60 minutes.

During the interview process, I will write to the larger sample group (of around 80 participants) asking for their involvement and seek their agreement and permission to continue. I will do this until I have identified at least 20 willing individuals.

Information and consent process:

I will set out in the participant information sheet and covering letter the aims of the research. If individuals are willing to participate, I will ask them to sign a statement agreeing to the research and thus obtaining their informed consent. This will take place five days after they have received the information sheet.

Details of the research to be performed

The chosen design and methodology of this study will be to adopt the repertory grid technique developed by George Kelly in the USA in the 1950s. Kelly brought his background as a mathematician into the field of social psychology and this technique aimed to explore personal construct theory, a means of understanding what people may think of others and what judgements an individual may make when they think about the way people act or behave, by interviewing subjects for their views on topics and issues. By prompting the interviewee with areas to think about and comment on, rather than asking them to answer a series of questions

or respond to a series of statements, this technique attempts to avoid proposing any biases the interviewer may have on the subject.

My aim is to interview four or five senior hospital doctors (consultants) about their views on the research topic (involving doctors in management). From there, I would put their views into a matrix (Kelly's aforementioned "grid") and ask a sample of 80 consultants to indicate, using a 6-point Likert preference scale, where 1 represents agreement with a word/phrase/statement at one extreme of the grid and 6 represents agreement with a contrasting phrase at the opposite end of the grid, their views on a particular issue or statement.

I have been influenced to adopt this design and methodology because it has, to my knowledge, not been used in this field of health/social science research before in this particular research area. The method strongly attempts to take on board the views of the interview subjects, who, in this case, are the key resource and decision makers in health care, rather than the biases of the interviewer, who is a "traditional" resource decision maker as an NHS manager. The proposed methodology and pilot interviewing phase should eliminate any sources of researcher/ interviewer bias.

Interviews will take place at the office/work environment of participants, or somewhere of equal convenience for them. There are no plans for interim analysis / reports, except for the pilot phase of interviewing, to test the robustness and validity of the interviewing technique. Feedback will be offered to research recipients if they want to receive it. Surveys will be sent to potential participants asking for them to be returned by a specified date.

Assessment of possible adverse effects:

The most evident risk of this trial is not obtaining individuals who are willing to be interviewed or willing to indicate their preferences on the aforementioned grid. I recognise that there will be an imposition on staff at the hospital in terms of their time, but I have aimed to keep this to a very minimal amount and only "inconvenience" willing participants. The anticipated benefits for participants are in engaging them in the management agenda, which is happening in the current NHS. Furthermore, I am hoping that the benefits to the directorate and organisation are such that greater understanding of the management agenda will aid future decision making and resource use.

APPENDIX J

INTERVIEW PROFORMA: Elements and Constructs

"What things come to mind when you think about…"

Emergent Pole	Element	Implicit Pole
	Leadership	
	Financial Resources	
	Management-specific education/training	
	UHL managers	
	UHL "top team"	
	Directorate management	
	Management meetings	
	Audit	
	Clinical Director role	
	Clinical Directorate model	
	Staff open forums	
	Star ratings	
	Management as a career	
	Change	

	Management of clinical colleagues	
	Your role	
	The multi-disciplinary team you're part of	
	Conflict	
	Private practice	
	"Pathway"	
	Your manager	
	Your organisation in three years time	
	Strategy	

Demographic questions

Gender: M F

Age Range: 30-34 35-39 40-44 45-49 50-54

55-59 60+

Length of Service (years) as:

- Doctor……………………………………
- Consultant ………………………………
- Clinical/Other Director…………………

Name (optional)…………………………………………

APPENDIX K – SURVEY PROFORMA

Survey: Involving doctors in management

Please indicate your preference for the "emergent" or "implicit" pole by circling only one appropriate number, where 1 = strongly agree with the emergent pole, 2 = slightly agree with emergent pole, 3 = agree with explicit pole, 4 = agree with implicit pole, 5 = slightly agree with implicit pole, 6 = strongly agree with implicit pole.

For example, for the theme **"oranges"**, the emergent pole is **"sweet"**, whilst the implicit pole is **"bitter."** If you strongly agree that oranges are sweet, circle the number "1", but if you agree oranges are bitter, circle the number "4" and so on.

Theme	Emergent Pole	Scale	Implicit Pole
Oranges	Sweet	**1 2 3 4 5 6**	Bitter

Please now indicate your preferences on the grid below:

Theme	Emergent Pole	Scale	Implicit Pole
Leadership	Good communication	**1 2 3 4 5 6**	Telling people what to do
Financial Resources	Inadequate and constrained	**1 2 3 4 5 6**	Is about discipline and creativity
Management-specific education/training for doctors	Necessary and highly desirable	**1 2 3 4 5 6**	Poorly undertaken and inadequate
UHL managers	Interested (in the service) and successful professionals	**1 2 3 4 5 6**	Divorced from the "coalface" with a focus on the bottom line
UHL "top team" i.e. Director level	Strong, hard working and successful	**1 2 3 4 5 6**	Not visible and reading the national priorities wrong

Directorate management	"Silo" management	**1**	**2**	**3**	**4**	**5**	**6**	Gets the job done
Management meetings	Too many, administrative and tedious	**1**	**2**	**3**	**4**	**5**	**6**	Focussed, effective and democratic
Clinical audit	Poorly defined with a "tick-box" approach	**1**	**2**	**3**	**4**	**5**	**6**	Targeted, useful and measurable
Clinical Director role	Crucial and defines the vision	**1**	**2**	**3**	**4**	**5**	**6**	Necessary to manage other doctors
Clinical Directorate model	Gets clinician buy-in	**1**	**2**	**3**	**4**	**5**	**6**	Creates unnatural alliances
Staff open forums	A good concept	**1**	**2**	**3**	**4**	**5**	**6**	Unconvincing, not successful nor well attended
Star ratings	Have set strategy and improved care	**1**	**2**	**3**	**4**	**5**	**6**	Wrong focus and micromanagement
Management as a career for doctors	Haphazard with no clear progression	**1**	**2**	**3**	**4**	**5**	**6**	Able to make more of a difference
Change	A welcome part of everyday work	**1**	**2**	**3**	**4**	**5**	**6**	Is imposed and creates resistance
Management of clinical colleagues	Difficult	**1**	**2**	**3**	**4**	**5**	**6**	Enjoyable because they are passionate about what they do
Your role in this organisation	Enjoyable, motivating and exciting	**1**	**2**	**3**	**4**	**5**	**6**	Futile, with uncertainty and lack of control

The multi-disciplinary team you're part of, i.e. those you work with on a daily basis	Equal and coordinated, with a clear structure	**1 2 3 4 5 6**	Divergent, egotistical and no clear purpose
Conflict	Is about understanding different views	**1 2 3 4 5 6**	Inevitable, uncomfortable and not easy to deal with
Private practice	Personal financial gain	**1 2 3 4 5 6**	Perverse incentive that creates a differing relationship with patients
"Pathway"	Unwieldy, expensive and uncertain	**1 2 3 4 5 6**	Transform health care in Leicester, in new buildings
Your manager	Honest, effective and supportive	**1 2 3 4 5 6**	Unclear, controlling and remote
Your organisation in three years time	Redesigned services in a more competitive environment	**1 2 3 4 5 6**	In transition (a building site) but much the same
Strategy	Centrally (government) driven	**1 2 3 4 5 6**	Being realistic with the "vision"

Demographic questions

Please indicate gender and age below:

Gender: Male Female **Age Range**: 30-34 35-39 40-44 45-49 50-54 55-59 60+

Please indicate your length of service (in years) for the following:

Doctor…………………Consultant ……………Clinical/Other Director (e.g. Lead Clinician, Head of Service)…… ………
Name (optional)…………………………………….. ……. Directorate…………….…….. …………….……….……….…….……