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The doctor–manager relationship†

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Abstract The different cultures of doctors and managers and the impact of these on their working relationships are described. A historical resumé tracks organisational change, the evolving nature of the relationship and the stresses it engenders. The phenomenon of scapegoating and an approach to managing risk is explored. Vignettes describing familiar problems, with suggested strategies for analysing them and resolving difficulties, are presented.

This is the final article in a series of three exploring working relationships between colleagues in mental health services. The first (Garelick & Fagin, 2004) looked at doctor–doctor relationships and the second (Fagin & Garelick, 2004) the doctor–nurse relationship.

It is widely recognised that good relationships between doctors and managers are essential for efficient delivery of healthcare. In an audit of 35 clinical governance reviews in mental health trusts, the Commission for Health Improvement (2003) concluded that investigation of serious service failures often reveals inadequate teamwork, lack of clinical leadership or poor doctor–manager relationships.

In a *BMJ* editorial, Smith (2001) highlighted how the increasing problems in the doctor–manager relationship contributes to unhappiness, stress disorders and early retirement. This point was illustrated by a 19th-century picture of a contemplative doctor alone with a sick child shown alongside a cartoon of a 21st-century harassed doctor trying to park his car to get to a meeting on time.

In this article, we examine the nature of the doctor–manager relationship and consider strategies that might improve this key working interaction.

We have to recognise from the outset that there are marked differences between the worlds of doctors and of managers (Box 1; Riley, 1998). It must also be acknowledged that, historically, medicine has had a stronger intellectual base than has management and that these disciplines differ in academic rigour, as evidenced by the different nature of their literature.

Box 1 The worlds of the doctor and the manager

The doctor	*The manager*
Focused on the individual patient	Focused on population groups and government agenda
Will not be primarily concerned with costs	Focused on treatment efficiently delivered within allocated resources
Has face-to-face contact with patients and families	Rarely meets patients or families
Expected to solve all presenting problems	Has to choose which problems to tackle
Has learnt to be independent and competitive	Expects to share responsibility with others
Trained to emphasise the scientific approach	Has to remember political factors and human motivations
Expects problems to have solutions	Expects to have to tolerate many insoluble problems
Expects to stay with the same trust for whole career and has job security	Has to move to gain promotion or because of redundancy
High social status and professional freedom	Medium social status and subject to bosses

†For a commentary on this article see pp. 250–252, this issue.

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Different environments, cultures and skills

Good managers are more comfortable with thinking in terms of systems and they accept more readily the complexity of organisations and the need to work effectively in teams. They are more adept at using negotiation to deal equably with conflict, whereas doctors often perceive negotiation as a means to gain concessions from the other side. Managers are familiar with the world of economics, an area in which doctors are often uninterested, which usually places them at a considerable disadvantage in modern healthcare systems.

The occupational life of senior managers and senior clinicians tend to vary. It is unlikely that senior managers will stay in post longer than 5 years, but it is still the norm that senior clinical staff will stay in a job for over 10 years, and sometimes throughout their senior career. Over the years, most clinicians therefore have to deal with a succession of new managers in their departments, and in their working relationships with them they may see the same problems arising again and again. Consequently, the first task of a new manager often is to overcome the cynicism of clinical colleagues.

Management–clinician interaction takes place outside the clinical situation with the patient. The natural habitat is the committee, where different rules of engagement apply. Communication is often through the written word (paper or electronic), rather than the verbal or physical interchange with patients.

Committee culture requires considerable expertise and astute handling, whether one be the chair or a member. The language used by doctors and managers to argue and convince each other of the advantages of a proposal is not the same as that usually used between clinicians, particularly if more resources are at stake.

These differences are reflected in a survey by Davies *et al* (2003), which found that chief executives were more optimistic than doctors about the state of the doctor–manager relationship. Interestingly, nurse-managers were even more supportive of the agenda of change in healthcare services than were general managers (Degeling *et al*, 2003).

Historical résumé

To understand the doctor–manager relationship we need to consider the nature of changes in the National Health Service (NHS). These have been charted by numerous researchers (e.g. Dopson, 1994; Harrison & Lim, 2003). Since its creation in 1948, the NHS has undergone radical structural shifts that have affected all NHS staff. The initial understanding (Ham & Alberti,2002) was based on the government's guarantee and funding of access to treatment for all citizens, with the medical profession taking responsibility for delivering care at an appropriate standard. This reflected an ethos of collective and corporate solutions to the welfare of all, in recognition of the enormous sacrifice made during the Second World War.

The infrastructure set up for the NHS at its inception remained largely intact until 1974. During this period, concerns about healthcare progressively increased both in government and in the community at large. Healthcare costs were escalating (3.5% of gross national product in 1950 to 6% in 1969), and the success of the NHS in dealing with acute conditions unmasked more chronic illness, which added to the rising costs. There was increasing awareness of local and regional inequalities in terms of allocation of funds, and a number of scandals occurred, leading to the publication in the late 1960s of *Sans Everything* (Robb, 1967). During the same decade, an inquiry into Ely Mental Hospital (Department of Health and Social Security, 1969) fuelled increasing concerns about the 'Cinderella services' (mental health, geriatric and community care services). In parallel with this, nascent pressure groups such as The Patients' Association, the National Association of Mental Health (now named MIND) and Community Health Councils made the patients' voice heard.

In the pre-1984 era, the manager could be thought of as a diplomat, attempting to find suitable compromise between clinicians and patients or carers when conflicts arose and demands were made. Between 1984 and 1991, the era of general management swept in. This gave managers a much greater say in the organisation and delivery of services. The introduction of the quasi-internal market in 1991 had a major impact on NHS culture. The managerial agenda no longer focused on the need to respond to internal organisational factors: it was required to meet central government agendas. This more assertive stance by government was fuelled by many circumstances, the most prominent of which was the need to reign in public expenditure. Throughout these changes, the relative influence of doctors and managers slowly shifted in radical but subtle ways. Initially, doctors were dominant, and they used their clinical experience to bolster their authority. Managers, at that time usually called administrators, simply gave what their title suggested – administrative support – without challenging the clinical view (Davies & Harrison, 2003). The arrival of general management, the internal market and, more recently, clinical governance, has put managers in the driving-seat, even in the face of physicians' opposition.

The change in job title from administrator to manager is indicative of the changing culture within the NHS. Among the historical derivations of the word 'administrator' we find the concepts of giving service and rendering aid. 'Manager' has among its early meanings someone who conducts the course of affairs, causes people or animals to submit to their control, even causes something to happen by contrivance. This shift in language reflects the progressive move to more authoritarian and centralised control within the NHS. The role of the administrator as a diplomat working to solve localised problems and to maintain homoeostasis in an organisation has been replaced by that of the manager, whose function is to secure major change to deal with centrally decided edicts and guidelines.

A clear pattern can be determined from the changes that have taken place over the past 35 years. There has been a substantial erosion of the traditional professional medical dominance and autonomy, and this, not surprisingly, has led to increased unhappiness within the profession and to tensions in the doctor–manager relationship.

Perpetual motion

The constant changes in the NHS in recent years have been mirrored outside of the UK. No country appears to be satisfied with the current state of its healthcare system. Reforms are being contemplated, organised or implemented across the world, some in direct contradiction to others.

Glouberman & Mintzberg (2001*a*,*b*) see structural divides in healthcare organisations. First, a horizontal cleavage separates clinicians, who work within the system and deal mostly with patients and their general practitioners, from managers, who primarily respond to outside organisations such as governments and funding agencies. Second, a vertical cleavage separates those irretrievably connected to the organisation (such as nurses and managers) from those involved with it but not so formally connected to it (the physicians and trustees). They contend that the lack of integration between these unreconciled worlds and mindsets is fundamental to an understanding of the difficulties in managing health services and one of the reasons for continuous processes of reorganisation. This inherent difficulty is independent of resource constraints but exacerbated by them. Such constraints remain a powerful and ubiquitous problem.

Different pressures are faced by doctors and managers in their day-to-day work. Doctors involved in the treatment of individual patients react to clinical demands. Patients do not frame these demands in terms of ICD–10, a taxonomy built on empirical and logical principles. Powerful and unconscious factors operate. Patients expect doctors, and hence the NHS, to relieve them of profound states of distress, of pain (mental and/or physical) and of fears of serious mental illness, chronic disability or death.

When we are unwell we place ourselves in the hands of doctors and nurses. This mobilises needs in us akin to those present in the child–parent relationship. Regressive forces express themselves in terms of a need for sustenance and reassurance that feeds into the expectation of what the health service should provide. Patients wish both consciously and unconsciously to have 24-h access to unconditional healthcare and the consequent reassurance that they can have respite from anxiety at all times. For patients, the National Health Service symbolises each individual's wish to have a nurturing parent constantly available – a National Breast Service – who also will sooth primordial fears.

Managers relate more to outside funding organisations responsibe for resourcing these conscious and unconscious needs without overburdening the taxpayer. The pressure on managers exerted by government comes from the electorate, who are, in fact, an agglomeration of all the individual patients, since we all visit a doctor at some time or other. What government and managers are faced with is an inherent contradiction: individuals demand a health service that meets all their needs, but the electorate (a collective of those very individuals) is reluctant to foot the bill. Governments are inherently vulnerable to such polarised interests because they constantly worry that any attempt to raise taxes jeopardises their electoral chances. This contradiction and anxiety is transmitted to managers, expressed as an unrealisable expectation to improve and extend the service within the existing resources.

Box 2 describes a recent dilemma that serves as an illustration of how the worlds of medicine and management can clash.

Box 2 A war of worlds

Asylum-seekers and illegal immigrants who become mentally ill, often as a result of their ordeals, are being referred to mental health services even though some of them are not entitled to free NHS care. Psychiatrists and other health workers find it very difficult to deny these people access to services. Managers, however, may feel duty bound to impose government directives, blocking acceptance by mental health teams and informing the Home Office of the patient's approach for help.

The clinical domain

Clinicians now feel that management has also entered into areas where before they themselves had general clinical autonomy (Davies & Harrison, 2003) (Box 3).

In the UK in the late 1990s, the switch from the internal market to centrally imposed diktat following a change of government made managers into government agents, following the political rather than the clinical agenda.

The international systematisation of medicine, with the introduction of case-mix measures, diagnosis-related groups and centrally agreed protocols and guidelines, makes medical care susceptible to management measures associated with income and remuneration. The imposition of national tariffs will become another step in this direction, leaving room for management to determine how clinical care is provided and how much is affordable. Incentives to doctors via remuneration under the new NHS employment contracts also place medical care under management control. Added to this, state regulation of medicine as a profession has introduced a system of inspection of standards (such as the Healthcare Commission), compulsory clinical audit, publication of league tables, clinical performance indicators, 'star ratings', gate-keeping arrangements between primary and secondary care, and so forth.

In the past, moral persuasion was relied on to encourage medical participation in effective and efficient systems of medical care and delivery, but failure by clinicians to regulate their own practice (evidenced by, for example, the Harold Shipman and Bristol Hospital inquiries) has invited governments to exercise a more regulatory approach.

A powerful element in this process of continuous change is the rise of regulation. Five new regulatory bodies were created in the NHS between 1998 and 2002, additions to an already crowded landscape. The self-directed (moral persuasion) model of regulation assumed that the NHS was fundamentally good hearted and had impeccable intentions. The current approach, however, is increasingly perceived by service providers to be a deterrence model which implicitly assumes that the NHS is amoral and that other, perhaps personal, motivations are put before the public good (Walshe, 2002). Although couched in terms of laudable public health aims, the process is definitely dictatorial.

The overriding theme is therefore of lack of trust and an erosion of professional influence, power and autonomy. Reflective practice derived from individual expertise and professional consensus, based on expert opinion, is being replaced by critical appraisal and a benchmarking bureaucratic model.

These changes are a major source of the conflict undermining doctor–manager relations. Although there may be some advantages to these developments, they will be acheived at the cost of rigid formalisation of care and a corporate utilitarian approach rather than an emphasis on individualised attention.

Box 3 Threats to clinical autonomy

Control over diagnosis and treatment Decisions on which tests and treatments are efficient and effective, the nature of procedures, who and when to refer, the nature of follow-up care

Control over evaluations of care Appropriateness of individual care or overall pattern of care

Control over nature and volume of medical tasks Doctors determining their own priorities, workloads and supporting activities

Contractual independence Unilateral rights to engage in extracurricular activities such as research, teaching, College work or private practice

Interdependence

In a complex health organisation such as an NHS trust, both doctors and managers are mutually interdependent (Box 4).

Clearly, managers and doctors have some things in common (Smith, 2003). Both professions usually attract individuals that work selflessly and hard, sometimes to their own detriment. Career paths are long and arduous, and incorporate an ethical dimension. Doctors and (obviously) managers respond to financial incentives and prerogatives, and both must assess and take risks. In both professions there are specialists, and both have the need for effective communication but a reputation for excessive use of jargon.

Despite these common factors, their different cultures and pressures can cause considerable difficulties in their relationships with each other.

The perpetual changes that clinicians are experiencing reflect the attempt of governments to grapple with what appear to be insuperable problems. Conflict usually arises out of financial considerations, but in the new climate of accountability, management also now monitors risk and handles complaints against clinical staff, suspensions, internal inquiries and external consultations.

An important dimension of mutual interdependence is whether both partners are equal. Doctors can manage, although perhaps not with the same level of expertise, but managers can't doctor. Managers will say that in order to manage effectively

Box 4 Doctors and managers: who needs whom?

Doctors need managers	*Managers need doctors*
To resolve complexity of the working environment, which needs managing	Doctors are the vehicle of the 'health delivery product'
To help them with unrealistic expectations	To ground them in the human and clinical reality of patient care
To mediate with the state	To translate government policy into clinical reality
To set boundaries of care	To recognise where boundaries are ineffective, unrealistic or inhumane
To act as repositories of negative comments from patients and to deal with complaints against the omnipotence of doctors	To contain their anxiety in certain situations
To have an overview of the needs of the whole service and not be influenced by parochial needs or those of the most powerful and influential	To inform them about the clinical realities in order to decide on apportionment of resources
To get the resources that are required to deliver the service	To use resources effectively and efficiently
To help them understand networking and committee skills	To communicate evidence-based clinical practice based on sound scientific principles

they need the support of doctors, but doctors rarely think that they need management support in order to practise effectively. Management skills are, however, essential for doctors heading a unit or clinical team.

Medical managers

In conjunction with these changes there has been a concerted attempt by government to involve doctors in management domains and thus take greater responsibility for the thorny and politically sensitive issues of resource management. This started with the Griffiths Report on management within the NHS (Department of Health and Social Security, 1984) and has gradually developed with the introduction of clinical and medical directors. Medical managers find themselves at the nexus between management and clinical agendas and predictably find their role stressful and demanding (Goodwin, 1996; Thorne, 1997). Their capacity to maintain a relationship and identity with their physician colleagues as well as fulfil management expectations is sorely tested both institutionally and within themselves.

In describing aspects of the doctor–manager relationship we may have given the impression that only the manager has to face issues such as limited financial resources. Doctors have to manage their time and resources too. Giving more time to one patient will often mean less for another. In managing their clinical workload they rely on their 'internal manager' to deal with the relentless clinical demand. Unfortunately, doctors are susceptible to overwork and many are not good at looking after their own needs (Gabbard, 1985). Like doctors, most healthcare managers also have an internal wish to care/cure, and some find themselves trapped by the expectation of fulfilling every patient's needs. This is more likely to occur when they are dealing with complaints, as this more direct contact with patients and families can lead to the loss of boundaries.

The dialectic is thus not just between doctors and managers, but is also an internal struggle within all of us and it can become a particular problem for medical managers.

Simpson & Smith (1997) have pointed out advantages of being a medical manager: their position as clinicians gives them increased credibility in the boardroom, and the fact that they have alternative careers, should management not work out, makes them more likely than their non-clinical management colleagues to speak out against what they consider to be unworkable decisions. Box 5 shows some of the downsides and the rewards of being a doctor in management.

Local solutions

The following vignettes illustrate some of the points we have described, showing local solutions to difficulties that might arise between doctors and managers.

Vignette 1 Divide and conquer

There are often marked differences in the clinical practice of doctors working within the same unit, let alone the same trust, and these are now likely to be examined by managers – a difficult and sensitive task. The consultants in a community-based admission unit were under constant scrutiny by management, owing to their inability to keep within their in-patient bed allocation. This reflected poorly on the figures that the trust sent to the Department of Health and affected its financial health. The consultants were compared unfavourably with those running another unit within the trust with similar number of beds. Several reviews were carried out, both internally by the trust and by external consultant agencies, which gave rise to a frequently (although obliquely) expressed management view that the root of the problem was weak consultants who were over-admitting patients. This resulted in understandably low morale and indignation in the consultants.

A subsequent reorganisation of the trust brought in new management personnel, and they revisited the problem. With the help of the clinical director, who explored the varying clinical demands on the service, they came to the view that a range of structural, organisational and staffing difficulties were particular to the unit and concluded that the doctors were not solely responsible for the higher admission rates and length of stay.

Vignette 2 Downgrading medical input

After lengthy negotiation, detailed proposals were presented by the consultant body for a new consultant post in response to increasing clinical demands and an opportunity to develop a dual diagnosis service.

Management were very resistant to the proposal, expressing the view that consultants are very expensive and proposing instead a non-medical team to help deal with the excess workload. However, the medical director and the clinical directors involved further examined the consultants' request and concluded that without a dual diagnosis service, demands on in-patient facilities would continue to increase and that the clinical needs of patients with dual diagnosis require a consultant-based service.

The local solutions arrived at in these vignettes depended on the ability of both managers and clinicians to stand back and take an objective view, consult with colleagues and the clinical director, achieve a consensus strategy, be aware of sensitivities, and avoid cornering or humiliating any individual or group of colleagues (private informal discussion is often very important). Timing in these examples was crucial: sometimes deferring to a more propitious opportunity will enable a more open-minded attitude from all parties and allow changes to take place. Finally, patience, persistence and a frame of mind that accepts occasional setbacks often pay dividends.

The third vignette illustrates a local problem that may well resonate nationally.

Vignette 3 Threats to existing services

A recent reorganisation resulted in several primary care trusts (PCTs) deciding to reduce their budget for mental health services, thus threatening existing services. A conflict arose between trust management

Box 5 Downsides and rewards of being a doctor in management (after Riordan & Simpson, 1994)

Downsides

- Accepting responsibility for matters that previously could be left to others
- Becoming unpopular with colleagues as a result of difficult service decisions made. Being considered a 'traitor to the profession'
- Being in the position of having to critically appraise colleagues' clinical practice and take action when necessary
- Reduced chances of receiving awards if they have crossed swords with influential people who sit on awards committees
- Management functions steal time from clinical work
- Having to delegate tasks to other colleagues
- The job can sometimes be overwhelming, with the possibility of burnout or ill-health if not tackled appropriately in time
- Risk of professional isolation
- Problems in being accepted by non-medical managers

Rewards

- Being in a position to attract resources for developments
- In a position to influence how government directives are implemented
- Having a major influence on developments and setting of standards of clinical care
- Financial incentives and awards
- Gaining status within the trust
- Working on the broader canvas of the organisation

> and clinicians, the doctors believing that management had not adequately represented clinical services, and management bemoaning lack of interest and participation of doctors in the difficult negotiations that had ensued with PCTs. An away-day was organised to explore the issues and a strategy was agreed during this. Its key elements were to identify what was taking place in the system and where the pressures were coming from, to work to achieve an agreed clinical view and avoid confrontation, and to negotiate with the local PCTs as a joint team of managers and doctors.

Ways of responding to the kind of difficulties exemplified in the vignettes are summarised in Box 6. It is important to enable individuals and agencies to withdraw or modify their proposals without feeling humiliation. Ideally, they should then develop jointly a suitable solution.

We have discussed the importance of searching for a dynamic understanding of these complex phenomena in two previous articles (Garelick, 1998; Garelick & Fagin, 2004). The vignettes in all three of our pieces show how easily in difficult circumstances a ‘them and us' confrontation evolves, and how problems often generated by financial deficits can, under pressure, be projected onto doctors, who themselves become the source of further difficulties. Conversely, doctors' mistrust of management and lack of awareness of financial imperatives can lead them to suggest that it would be better if they ‘got rid of the managers'. Scapegoating is a pervasive phenomenon in institutions and organisations.

Scapegoating

The common theme in the three vignettes above is the search for someone responsible for the problem, when in fact it is a consequence either of failures in the healthcare system or of clinical demands. Scapegoating is ubiquitous in society and has become particularly prominent in mental health services with the recent plethora of suicide and homicide inquiries (Szmukler, 2000). The concept of the scapegoat derives from a religious ceremony in biblical times. The essence of the procedure was the transfer of a person's guilt by means of a magic rite onto an animal such as a goat. The sacrifice of the goat resutled in exorcism of blame. Kraupl Taylor & Rey (1953) note that such procedures have been closely associated with aggressive and excessively punitive attitudes.

Scapegoating can bedevil doctor–manager relationships in a process of cyclical transferences. Societal guilt regarding insufficient finance for the NHS is transferred onto managers, accused of poor financial and organisational acumen; to avoid becoming sacrificial goats the managers displace the guilt onto the doctors, who are then questioned about their skills and rational use of health resources. This dynamic can operate in the reverse direction. Doctors also struggle with feelings of guilt that they might not have done enough, or might have recommended insufficient or ineffective treatment for their patients. This unpleasant doubt is often displaced onto managers, who are blamed for not offering enough resources or facilities to improve patients' ill health. These dynamics can only exacerbate the cultural differences between doctors and managers and can cause damaging splits in an organisation.

Box 6

Locating the origin of the problem

- Is it external or internal? For example, does the strategy to reduce budget arise from PCTs or from trust management?
- Is the proposal coming from the chief executive or from middle managers trying to balance their own budgets?
- Is the trust board aware of all negotiations?
- Is there a non-executive member of the trust board who has responsibility for the area concerned?

The clinical response

- Discuss at a senior medical staff meeting
- Work to obtain a unified clinical view and develop a clinical strategy
- Enlist multidisciplinary and user/carer group support
- Try to incorporate some elements of the proposal in the response
- Give the clinical director a clear mandate and ensure that he/she is in agreement

The devil is in the detail

- Ensure that there are accurate costings for the proposal
- Provide costings for any alternative proposals or options
- Examine the impact on mandatory training requirements, duty rotas and indirect services such as consultation and support

Backs to the wall

- Recruit the views and support of:
  - local GPs
  - professional organisations
  - national user groups
- Consult the regional strategic health authority
- Brief local Members of Parliament
- Write to the Department of Health and Minister concerned
- Be extremely circumspect with the media

A systems approach

Using a systems approach to review these problems can be helpful in avoiding pitfalls in the relationship. A particularly impressive example is that adopted by the aviation industry, in an approach pioneered by Raison (2000). His work was instrumental in stopping the aviation industry from making the automatic assumption that an accident was caused by pilot error if mechanical failure had been excluded (compare this with the assumption that suicide or homicide must be due to a medical error). His basic premise is that humans are fallible and errors are to be expected. Well-functioning organisations develop systems of support and strategies to mitigate such human vulnerabilities. This is an organisational task in which all staff need to work together. In Raison's model, it is when the gaps in the tiers of organisational support and protection align themselves that errors come through the system and become manifest. Thus, identification of risk requires examination of the system as a whole. This is a model that can be very helpful in analysing and finding solutions to perceived clinical and managerial failures.

What can be done to improve the relationship?

It is important to acknowledge from the start that when doctors and managers first interact, a background of distrust exists between them for all the reasons outlined above. How do we overcome this inauspicious beginning? As with all biases and preconceived assumptions, it needs to be put to the test, both by joint working arrangements and frank and open discussions.

When the pressure is on it is easy, and perhaps understandable, to retreat to a 'them and us' position, which tends to reconfirm old ideas and sour relationships. The committee meeting becomes a battlefield, following diverse and sometimes irreconcilable agendas, rather than an opportunity for joint and realistic resolution of problems. Malcolm *et al* (2003) suggest that unless a 'third logic' is accepted, the gap between doctors and management will remain. They advocate the restoration of clinical autonomy as opposed to purely market or bureaucratic models, with clinicians becoming collectively and professionally accountable for the quality and cost of their decisions.

A large healthcare organisation in the USA has fostered a change in organisational culture, based on joint leadership and an acknowledgement of mutual dependence through the alignment of objectives that are not focused solely on individual patient care, use of resources or productivity (Crosson, 2003). It also provides management education strategies for clinicians wishing to take up leadership roles.

In The Netherlands, external peer review often reveals managerial rather than clinical problems. This suggests that self-regulation by doctors is likely to be more successful than regulation imposed by clinical managers (Plochg *et al*, 2003).

A comprehensive review of the problem (Edwards, 2003) suggests that redefining clinical autonomy in order to preserve it and ensure that it encompasses accountability and responsibility would be an important step and would facilitate clinical leadership. Such issues need to be dealt with at the meta-organisational level. Within an organisation attention needs to be focused on understanding the psychological processes that are taking place at the individual, group and systems level (Obholzer & Roberts, 1994).

Various authors have put forward suggestions for establishing more common ground between doctors and managers (e.g. Atun, 2003; Edwards *et al*, 2003; Müllner, 2003; Nash, 2003). Box 7 shows a distillation of these, and Box 8 gives the website addresses of a few organisations that offer further healthcare management information and training.

Box 7 Strategies for improvement

Relationships
- Respect for differences between managers and doctors
- Ability to develop goals and strategies that are aligned with the clinicians involved
- Education – managers to learn about medicine and doctors about management techniques and how to navigate bureaucracies
- Staff stability to enable working relationships to develop

Reflective practice
- The capacity to stand back when there are conflicts in order to analyse the problem
- Consult a disinterested party

Educational
- For both doctors and managers to be educated on the impact of psychological processes at the organisational level
- Develop an academic basis for management and medical management/clinical leadership
- Foster early interdisciplinary education. Managers attending ward rounds and doctors attending management programmes
- Better management research to redesign care processes based on best practice

Box 8 Useful information on

The following may be useful to those wishing to seek further information or training:

http://www.gmc-uk.org/standards/manage.htm	General Medical Council (1999) *Management in Health Care – The Role of Doctors*
http://www.bamm.co.uk	British Association of Medical Managers
http://www.aamc.org/	The Association of American Medical Colleges gives details of joint MD/MBA training programmes offered by universities in the USA
http://www.nihcm.org/	The National Institute for Health Care Management Research and Education Foundation, another US organisation, hold forums and briefings for various healthcare bodies

As with all complex problems, a variety of approaches need to be taken, and these rely on an understanding of organisational and group behaviour, systems theory and psychodynamics. Just as important is the supplementation of any solutions with more educational and developmental work in which doctors and managers can jointly participate.

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MCQs

1 The following cultural differences distinguish doctors from managers:
a managers tend to use jargon
b doctors are good team players
c doctors focus on the individual
d managers have to move jobs to gain promotion
e managers focus on the organisation as a whole.

2 Which group is least supportive of managerial modernisation initiatives?
a trust board non-executives
b chief executives
c doctors
d nurse-managers
e financial directors.

3 Managers and doctors have the following areas in common:
a both professions have specialists
b both have long career paths
c both have an interest and expertise in finance
d both have ethical responsibilities
e both are skilled in navigating complex bureaucracies.

4 Scapegoating is:
a a desire to raise standards in the organisation
b a method of transferring guilt
c a recent phenomenon
d often associated with extra-punitive attitudes
e a magical way of dealing with guilt feelings.

5 The doctor–manager relationship could be improved if:
a both doctors and managers were educated about psychodynamic processes within an organisation
b interdisciplinary education were fostered early
c regulation of clinical activity by external agencies was increased
d greater managerial staff stability were ensured
e respect for differences between managers and doctors were engendered.

MCQ answers

1	2	3	4	5
a F	a F	a T	a F	a T
b F	b F	b T	b T	b T
c T	c T	c F	c F	c F
d T	d F	d T	d T	d T
e T	e F	e F	e T	e T

‘When we cannot act as we wish, we must act as we can’[1]

Invited commentary on... The doctor–manager relationship

Nicholas Sarra

The NHS is an organisation populated by groups who often compete with each other over sparse resources and avenues of influence. Professional rivalry is endemic in this situation as groups position themselves to acquire, consolidate and protect professional territory.

In order to communicate and position themselves, professions are obliged to use the discourses that have currency and validity in the wider system. This means using the new managerialist rhetoric of audit and accountability so dominant in the public sector. The rhetoric includes a clustering of terms familiar to anyone working in these services: ‘performance’, ‘targets’, ‘action plan’, ‘outcomes’, ‘empowerment’, ‘corporate’, ‘politically aware’, ‘risk management’, ‘stakeholder’, ‘evidence-based practice, ‘bench-marking’, ‘good practice’, ‘efficiency’, ‘effectiveness’, ‘quality control’, ‘accountability’, ‘external verification’, ‘transparency’, and so on.

1. Terence, *Andria*, 805: ‘Ut quimus, aiunt, quando, ut volumus, non licet.’

In the UK, their origin can be traced to the Thatcher years and the increasing migration of the language of audit from the financial sphere to all aspects of our working lives (Shore & Wright, 2000: p. 60).

Unless professions and individuals within them employ this kind of rhetoric they may not achieve influence and may also be peripheralised. They then run the risk of being characterised as irrelevant or, if more powerful, as resistant and 'non-corporate'. The new managerialist rhetoric that I am describing therefore becomes a powerful and coercive tool with which professional identities and relationships are shaped. None the less, behind the scenes and despite the language of accountability and transparency, people go on doing what they have always done and probably always will do. That is, they are as likely as ever to fall back on primitive processes of relating, among which Garelick & Fagin (2005, this issue) identify scapegoating and projection. There are also the informal processes of organisational life, the 'who knows who' ways of getting things done and the importance of gossip as a vehicle for alliance-building (Elias & Scotson, 1994). In other words, I am here referring to the dynamics of power relations and the ways in which people position themselves and others as insiders or outsiders, the phenomenon that Garelick & Fagin mention briefly as 'them and us'.

Them and us

The 'them and us' issue is particularly pertinent to the NHS, given its complex proliferation of professional identities and interests. Of course, doctors and managers are not unique in their positioning of each other in this way. The same dynamic potentially operates between all groups, since it helps achieve cohesion. Cohesion in group terms is crucial and may be linked to survival and the unconscious anticipation of a task that may require a fight or flight response. Cohesion within one group is therefore often achieved at the expense of another group. Gossip within groups about other groups frequently contains themes that confirm to the interlocutors their sense of belonging and alliance. Such themes might be articulated as 'They are different from us and a bit suspect – they are outsiders. We are similar and somewhat better – we are insiders'.

The rise of the culture of new managerialism is central to an understanding of the dynamics of doctor–manager relationships and the way that it exacerbates the inherent 'them and us' dynamics of intergroup behaviour. The language of empowerment and devolvement thinly disguises an increasing tendency for centralisation and control by a government whose own targets include re-election on the back of 'continual improvement' of public sector services. The aim is that workers internalise the discourse of audit and become self-governing units and accounting commodities. So internalised has this discourse now become that it seems to many to be common sense and unquestionable.

Control and divide

So what is wrong with all these proscriptions for governance and accountability? First, health service staff are not truly 'empowered' to work with anything outside of a very narrow set of centrally determined references. Meaning is therefore taken away from the 'vested interests' and 'cosy circles' of local professional groups and is derived from politically driven government objectives. This tends to demoralise individuals, whose work tasks can begin to feel meaningless and irrelevant at a local level since all meaning is derived and legitimated centrally. Furthermore, the emphasis is on systems of control rather than, for example, the complexities of doctoring. As Power (1994: p. 19) puts it:

> 'What is being assured is the quality of control systems rather than the quality of first order operations. In such a context accountability is discharged by demonstrating the existence of such systems of control, not by demonstrating good teaching, caring, manufacturing or banking.'

The interprofessional divide that so often separates doctors and managers also functions as a defence of independence and autonomy. A boundary of non-communication and non-engagement helps to protect the status quo. New managerialism challenges the traditional power structures of the medical profession and in some situations has brought about a crisis in role for the latter, especially in terms of leadership and authority within teams. Doctors who become managers (the reverse is probably a rarity) run the risk of being treated like collaborators with the enemy. Considerable emotional labour is required of those asked to straddle the split.

Mutual sense-making

So what is to be done? Garelick & Fagin highlight some examples of useful interventions. In all of them, managers and doctors are obliged to talk to each other both in a formal sense regarding a task but also, presumably, less formally over their coffees and lunches. My point is that both groups require ongoing opportunities for dialogue which must extend beyond the positioning and constraints of highly structured committee meetings. In other words, the opportunities for dialogue must be

complex and allow for different avenues through which the working relationships can develop. Owing to the power dynamics between the groups, it is helpful to invite experienced facilitators to some encounters. This offers an opportunity for the development of mutual sense-making as opposed to parallel universes.

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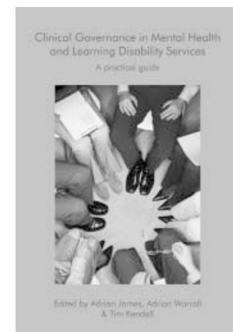

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