New Models of Clinical Management

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Introduction and Summary

This paper discusses the development of clinical management in the UK and explores some of the current trends and issues. The definition of clinical management it uses concerns the management of clinical teams, processes, resources and outcomes; it therefore includes Medical Directors and Clinical Directors, but excludes General Managers who may have been doctors. It explores the difference between the “deficit” model of clinical management, which focuses on the shortcomings of clinical managers in relation to a standard model of private sector managers and a “learning” model based on the phased introduction of medical management processes which build on the current strengths of medical managers.

Clinical Management

Clinical management signifies the management of clinical processes, activities and the resources used by clinical teams. At its heart is the management of patient treatment and care, which is a management process requiring analysis (diagnosis), planning and monitoring as well as outcome review (clinical audit). In recent years standards for the procedures to be performed, the outcomes to be achieved and the acceptable costs of treatment have been more closely proscribed by purchasers or commissioners in the UK. At the same time clinicians have come to accept the use of agreed protocols defined by “evidence based medicine. These may be seen as aspects of a European form of what in the USA is described as managed care. This is nevertheless a highly professional process in that the clinical team will have very specific expertise in their field and will exercise their own judgement as to the standards to be employed. The role of the clinical manager is not to supervise the clinical team in the performance of its professional function, but to ensure that there is effective planning, monitoring and peer review.

A focus on the total patient care pathway and its management by doctors and nurses is the starting point for management of the resources used in patient treatment and care and of the investment required to continue to improve the quality and cost effectiveness of health services. This requires clinical management to look beyond the boundaries of departments and hospitals to consider the total health needs of patients and the response of the health and care system.

Labelling this clinical management implies that clinical staff (doctors or nurses) are enabled to take a wider role in hospital and health management than is traditional, in the UK. For example traditional “Heads of Department” largely focussed on professional issues within their departments and on representing their colleagues. The new breed of clinical managers were usually designated as Medical Directors and Clinical Directors. It is also arguable that in primary care the leaders of GP Fundholding Groups played a similar role in management though these are not usually described as clinical managers. The role of clinical management is still evolving in the UK there is still considerable variation in the functions of clinical managers (1) and uncertainty as to how it should be carried out (2) and whether it is attractive to doctors (3)

Why clinical management is difficult

It should be no surprise that clinical management is difficult. The so called “contingency theory” of management suggests that the difficulty of management increases with:

* Size. The number of relationships to be managed within the organisation increases exponentially with size. For this reason hospitals of more than 1000 beds are notoriously difficult to manage and are often broken down into sub units to make them manageable. Within a hospital clinical directorates of between 100 and 200 beds are often identified as management units.
* Complexity of goals and tasks. Teaching hospitals are particularly difficult to manage because they have complex academic and health goals and many different professions indicating the complexity of the tasks they face. To manage complexity, centres of excellence may be identified for particular specialties at different hospitals. These can provide leadership to a network of departments in other hospitals. If hospitals try to become centres of excellence for too many specialties it creates management difficulties.
* Predictability of tasks and outcomes. The mix of emergency and elective treatment and the range of severity of cases makes hospital activity difficult to plan and manage. Even the simplest categorisation of Diagnostic Related Groups (DRGs) has almost 500 categories and within DRGs there may be wide variation in severity. Elective treatment centres are sometimes separated from emergency and complex treatment because they require different forms of management.
* Cross boundary. Tasks that require coordination between different organisations are also particularly difficult. Clinical management of chronic care requires coordination with many different agencies and groups, not least the patient and their family and is difficult when many different agencies are involved.

All of these factors make clinical management difficult and unique they call for a focus on management of clinical tasks and processes centred on the patient.

The Background to Clinical Management

The concept of clinical management as a distinctive branch of management has emerged relatively recently. From the 1950s “Medical Superintendents” provided leadership and direction for doctors working at a hospital but played little role in the management of services or finance. In 1974 hospitals and other local health services were reorganised to come under the management of local Health Authorities. At this stage local Chief Medical Officers took a lead in planning services to meet local health needs but they had virtually no role in the day to day management of services. A review of hospital management lead to the publication of the “Cogwheel Report”, this introduced a series of committees to manage hospital services by consensus. In theory committees representing doctors, nurses and administrators were supposed to agree on actions at every level from the hospital ward to the board of the hospital. In practice such committees proved very ineffective and were often circumvented. The minutes of committee meetings make depressing reading with continued discussion of issues such as staff car parking and little sign of any progress or decision making. The committees had considerable power to prevent change from happening but were very ineffective in responding to new demands or making change happen.

In 1983 a further NHS Management Inquiry (often called the Griffiths Report) asked the question “who is in charge” and found that it was impossible to get a clear answer. It was therefore proposed to introduce a simplified form of command and control in hospitals. General managers would take overall responsibility with a system of delegation and clear responsibility for costs and outcomes. This required doctors to take responsibility for the use of resources, since their decisions determined the cost and quality of services. This lead to a long running programme to develop systems for “Resource Management”. From the start this programme had two elements, on the one hand it was necessary to introduce computer based systems to measure the cost and outcome of hospital activity, and on the other, it was necessary to create management processes involving doctors taking responsibility for costs and outcomes.

Computer based “resource management systems” were designed to apply standard costs to medical procedures, tests and other uses of resources. On this basis costs were then allocated between the clinical department ordering the resource, which was to be held responsible for the rate at which resources were consumed and the department providing the resource or service which was to be responsible for the efficiency with which resources were provided. This is of course much more complicated in a hospital setting than in other industries and there are still difficulties in establishing standard costs. The most difficult aspect of resource management, however, was not the computer system but the human system of clinical management.

The most advanced model of clinical management to emerge from the resource management programme was developed by Guy’s hospital in London (4). In 1986 they adopted a system of “Clinical Directorates” taken from the John Hopkins hospital of New York. The clinical directorates were each supported by a Business Manager and a Nurse Manager reporting to the Clinical Director who in turn reported to the hospital Medical Director.

Issues in Clinical Management

This system which was publicised widely in 1998 with a videocassette explaining the principals of management it embraced was widely followed throughout the NHS. However, it was quickly discovered that a clinical directorate structure was not sufficient to make clinical management succeed. The main difficulties in making such systems work included:

* The role of a Clinical Director was often unclear, it was a part time role and the conflict between their professional role and their role in management was difficult (5).
* Medical Directors and Clinical Directors found themselves both representing their colleagues to senior management and representing management to their fellow doctors, while this is a traditional middle management problem, doctors often found it very difficult (6).
* The post of Clinical Director was often very difficult to fill. It was not seen as a long-term career option by most doctors and was not particularly well rewarded in relation to for example merit awards or private practice (7).
* There was still a divide between the professional management of clinician performance in relation to their technical competence and patient outcomes and their use of resources.
* Resource management systems were inadequate to allow clinical directors to exercise real control, computer print outs were often inaccurate, late and very complicated.
* In general doctors lacked management training and skills (8)

In response to these issues some hospitals tried a structure with a smaller number of large clinical directorates on the grounds that this reduced the cost of management and the problem of finding clinical directors. This also made it possible to delegate more responsibility to this level and to allocate finance and personnel staff to work with each clinical directorate. Others created smaller clinical directorates because this reduced the span of control and fitted better with existing clinical firm structures. Resource management systems were gradually improved by better definition of health processes. At a national level a programme to train doctors in management skills was initiated, over 2000 doctors attended management training courses and 260 attended Business Schools (9). The British Association of Medical Managers was established in 1991.

In 1991 Thatcher Government introduced a further reform to the structure of the NHS. They introduced the “internal market” separating Health Authorities, as purchasers of health services, from hospitals and other providers which were to be run as independent “NHS Trusts” with their own board of management. This development gave further impetus to the development of clinical management because clinical directors were now directly responsible for the volume, cost and quality of services defined in contracts, which were demanded by Health Authorities. This meant that clinical directors could help their clinical colleagues to maintain their contracts and ultimately their jobs.

A number of other steps further strengthened the role of the clinical director; for example hospital managers became involved in setting merit awards so that performance as a clinical director could be rewarded. Doctors were employed by NHS Trusts, rather than by Health Authorities. Information systems were improved, as they were central to the funding of NHS Trust. And performance information in relation to the Patient charter and other outcome measures became more generally available. All of these steps have been described as building a bridge between clinicians and management. However it could be argued that for the most part such steps were aimed at bringing the clinician closer to management rather than bringing management closer to the clinician. After all a bridge is best built from both sides..

Perhaps for this reason, studies suggest that even in 1998 clinical management was still regarded with suspicion by most senior doctors. Though junior doctors appear to hold a more positive view of the need for clinical management and show greater interest in spending at least part of their career in such a position.

The greatest and least expected success of these reforms was the development of GP Fundholding. This was an unexpected consequence of moves to give GPs more choice and responsibility. GPs took up and devised new forms of fundholding. Leaders emerged who lead new initiatives and developed and demanded new types of service. These leaders must clearly be seen as clinical managers though they adopted a different approach to clinical directors (10).

The Blair Government introduced its health reform programme “The New NHS” in 1998. This tried to retain the best aspects of the previous reforms but changed the language and culture of the market place in health care. They replaced “contracts” with “long term service agreements” and in place of GP Fundholding, which was taken up by 50% of GPs they introduced universal Primary Care Groups responsible for advising on the commissioning of services from hospitals and other providers. They are also advocating an approach to management with less emphasis on command and control and greater stress on the involvement of staff in management decision making.

At the time of these latest reforms there was considerable concern at the failure of the professional and management structures of the NHS to deal with problems of poor technical clinical performance. A number of cases came to light where despite widespread knowledge of the inadequate performance of certain doctors neither the doctor’s colleagues nor local management felt they could take action. One response to this situation has been to redraw the responsibilities of general managers so that they bear a direct legal responsibility for clinical quality.

At the same time clinical governance procedures are being introduced to ensure peer review of outcomes and performance. Both these steps give further impetus for the development of the role of clinical directors and reduce the remaining gap between what have in the past been seen as professional issues concerned with clinical judgements and performance and management issues concerning use of resources (11)(12).

Clinical governance also clearly extends beyond the walls of a hospital to involve all aspects of a patient’s treatment and care from primary and secondary care teams also broadens the scope of clinical management requiring skills in network management from both doctors in primary care and doctors in hospitals. Peer review is required in both primary and secondary care and it is important to look across the total care process from the patient’s perspective.

It is also important to note that all the forms of clinical management discussed above have involved a part time commitment. Clinicians still find that they need to retain a clinical workload while using one or two days a week for clinical management.

Deficit and Development Models of Clinical Management

The background to clinical management is provided by the “professional” model of hospital management, best enunciated by Mintzberg (15) in which the main patient treatment activities of the hospital are determined on the basis of professional training and a tacit understanding of roles and responsibilities. This was the justification for consensus management. Under this model clinical management is largely concerned with establishing appropriate agreements with professionals groups who are represented in the management structure but operate within a separate sphere of professional competence. In practice it meant that doctors had a great deal of stopping power and little effective accountability. The greatest weakness of this approach was that it produced a bias towards the status quo and an acceptance of the second best.

When general management was first introduced in the NHS the aim of the Thatcher government was to introduce best practice from the private sector to the public sector. This was a challenge the professional model and the power of professionals within the NHS. Relatively simple messages about having clear accountability and lines of authority were taken from private sector management and applied to the health service and there was a particular emphasis upon financial control and management budgeting. The result was mixed, there was some increase in the rate at which patients were treated, and greater attention to issues of importance to the public, such as the treatment of the elderly and NHS Trusts but in general such gains were seen as “at the expense of” traditional values.

Clinical directors were seen as just like private sector managers but lacking in skills in general management and financial management in particular and were also seen as weak in personnel and information management. Training and development programmes were established and support staff, such as business managers (often with a nursing background) were provided to make up this deficit. Later when the internal market was introduced further training was provided in contract negotiation. This “deficit model” of clinical management essentially assumed that clinical management is just like any other management role in a large industry but with some deficiencies in the skills of incumbents. While some individuals achieved a great deal in clinical management many clinicians remained reluctant to participate.

An alternative model of clinical management may be built on their strengths gained from experience and training. Thus clinicians spend long periods learning in teams; they are used to networking with colleagues and problem solving with patients. They are trained to consider the patient’s total circumstances and to listen and learn from patients. A model of clinical management based on such strengths would place emphasis on supporting the review and application of evidence-based medicine, sharing best practice and examining the total treatment and care of patients. This model is best exemplified by GP Fundholders, who became involved in all these ways and achieved a great deal.

A realistic model of clinical management must take all these aspects into account, recognising that a hospital is dependent upon professional standards of behaviour but that professional decisions should not be taken in isolation from other management considerations. This does require a broader involvement in management and an understanding of business issues for the hospital. However, a clinical director must also be encouraged to build on strengths in reviewing clinical practice and building network relationships.

While in the past there has been a tendency to define a role in clinical management on a theoretical basis and then try to find people who can meet the requirements of the role, a more promising approach may be to focus on the processes of clinical management. Introducing clinical management processes in a phased programme of change makes it possible to develop the role of clinical management as processes and skills are built up. It also allows for more innovation in clinical management processes and relationships. This could be called a learning model of clinical management.

Reviewing and questioning established patient treatment procedures, raises many questions that provide an agenda for clinical management action. For example it may be relevant to ask how the total patient care process is managed? What choices and options are put to the patient? Are the right people involved at the right time in patient treatment? And are resources being used in the best interests of the patient and the community? Such questions have far greater resonance for clinicians than a discussion of budgets and spending limits.

The wider adoption of this learning approach to clinical management can be seen to be changing attitudes towards such posts, in the past doctors have shown suspicion and uncertainty about such roles more recently however junior medical staff are showing greater enthusiasm for clinical management roles in hospitals (13).

Developing Clinical Management Processes

A learning approach to clinical management allows clinical teams to develop processes and skills over a number of years as part of a change management programme (14). Rather than attempting to involve clinicians from the outset in detailed management of budgets and staff it may be better to start by involving them in issues which interest them and in which they already have skills. Thus for example clinicians may be involved in:

* Health Process Redesign: Examining health treatment and care processes from the patient perspective to improve the quality, speed and co-ordination of services and reduce the cost of delay and repetition.
* Health Team and Network Management: The review of processes will lead to an examination of team roles, for example, can nurses undertake some of the standard tasks now undertaken by doctors, or could some processes be moved out of hospital to the GP. This leads to an examination of team roles and relationships between different parts of the health network. It also provides the basis for introducing a clinical management structure.
* Clinical Audit and Evidence Based Medicine: As processes are redesigned and team roles changed it will be important to continue to review clinical practice and ensure that they incorporate lessons from evidence based medicine. This process establishes a discipline of review and outcome follow up.
* Resource Management: Adds a further dimension to clinical audit, it requires additional information about the cost of each activity and it requires further training reinforces clinical management responsibility structure.
* Planning and Budget Management. Once clinical teams have confidence in using information about the cost of activities they can readily be involved in decisions about the planned level of activity and costs. This may include decisions to make savings in some areas in order to invest in new developments and equipment.

Naturally the issues in which clinical staff have expertise and interest will vary from hospital to hospital, it may be that in other circumstances it would be better to start by involving doctors in planning and budget setting. The main point is to build up clinical management processes in a step by step programme so that confidence and trust is built up.

This also implies that the organisational form should follow from the functions defined by clinical management processes. For example, in the New Edinburgh Infirmary a review of patient care processes led to a redefinition of Accident and Emergency and Admission procedures, this in turn established a need for integrated clinical management of all unplanned admissions. A further review of patient treatment led to the definition of clinical ward areas with similar medical, nursing and support service requirements and this again defined the need for integrated management of new clinical departments. Having been involved in these reviews doctors and nurses accepted the case for integrated clinical management and the reviews themselves set the initial budgets and performance targets for the departments.

Conclusion

A learning approach to clinical management may need to be introduced over a period of 3 to 5 years, in order to allow time for the development of the whole organisation and management processes. However, it is more likely to succeed than an attempt to impose a predetermined model of general management. And because it builds on existing strengths and skills it is more likely to maintain the support and confidence of clinical staff. The precise order in which clinical management processes are introduced will of course vary depending upon the circumstances of the hospital. What is important is that clinical management should be developed step by step, as new management processes are introduced and clinical teams gain skills and confidence.

This approach may lead to the evolution of forms of management much more appropriate to the clinical situation. It will give emphasis to the management of the patient’s treatment and care across the total health and care system. This in turn may lead to structures and systems, which respond to patient needs rather than reflecting traditional professional boundaries.

At the same time a recognition that clinical staff can contribute to different management processes may suggest forms of clinical management which share responsibility and are better suited to the time constraints of clinicians in management. This may suggest a model built upon networks and mutual learning and support rather than a command and control structure.

Building management systems around the patient and clinicians has more chance of success than attempting to turn clinicians into standard managers and a great deal more likelihood of being accepted and valued.

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