Doctors and managers: poor relationships may be damaging patients—what can be done?

N Edwards

Qual Saf Health Care 2003;12(Suppl 1):i21–i24

The problem of poor relationships between doctors and managers is a common feature of many healthcare systems. This problem needs to be explicitly addressed and there are a number of positive steps that could be taken. Firstly, there would be value in working to improve the quality of relationships and better mutual understanding of the necessarily different positions of doctors and managers. Finding a common approach to managing resources, accountability, autonomy, and the creation of more systematic ways of working seems to be important. The use of costed clinical pathways may be one approach. Rather than seeing guidelines and accountability systems as a threat to autonomy there is an argument that they are an essential adjunct to it. Redefining autonomy in order to preserve it and to ensure that it encompasses accountability and responsibility will be an important step. A key step is the development of clinical leadership.

important part and so the problem may have other origins.

THE PROBLEM

There is limited research in this area but there does seem to be a consensus that at least part of the problem relates to a number of changes in society and health care more generally, which have altered the nature of the relationship between doctors, their patients, and the organisations for which they work. In the United States Silversin *et al*⁴ argue that this represents a fundamental violation of the psychological contract with the medical profession and Ham and Alberti make a similar argument for the United Kingdom.⁵ The old contract promised a different balance of contribution and rewards from that currently on offer, one in which there was relatively high pay, autonomy, deference, and insulation from the exigencies of healthcare markets or government policy. This is clearly no longer available.

The most commonly cited cause of tension is pay and workload, and in the United Kingdom the idea that managers would be able to make consultants work outside the usual working week is one of the reasons most often quoted for the rejection of the consultant contract. Doctors complain about these issues in many other systems. Mechanic argues that a particular problem with workload is the expansion of what is possible in terms of investigations, treatments, and other interventions.⁶ This means that consultation times are increasingly inadequate to be able to provide the sort of service that most physicians would wish.

The next most commonly cited set of reasons for tension relates to changes in attitudes to clinical autonomy and the growth of a culture of accountability. Although in the United Kingdom doctors are still the most trusted of all professions, the general reduction in trust and deference in society has meant that government and the public have been increasingly demanding in the way they hold healthcare providers to account. High profile medical scandals have increased this pressure. In addition, the growing costs of health care and its growing share of the economy has meant that the decisions of doctors have come under scrutiny and there are increasing attempts to control it.

A second assault on autonomy has come from an increasingly consumer minded public who have much more access to information and have high, not always reasonable, expectations about what health care can achieve. They are used to the often slick and customer focused approach of

Relationships between doctors and the organisations in which they work may not be in crisis but there are clearly reasons for concern.^{1,2} The problems find most tangible expression in the relationships with the managers of the organisation. In the United Kingdom consultants rejected their new contract on the grounds that it gave too much power to managers and the medical press carried a surprising amount of quite vitriolic attacks on the integrity, motives, and education of managers. A study by Davies *et al* found that managers were more optimistic about relationships than their medical colleagues and that even doctors involved in management positions expressed serious misgivings about the state of relationships. Just over a quarter thought they were likely to deteriorate.³

In the United States, hospitals are concerned about the disaffection among physicians, which in some cases has led to their defecting to establish rival specialist hospitals. Conflict between doctors and managers seems to be a common problem in many systems. In the United Kingdom there has been a tendency to blame government as managers have become identified with a regime of performance management and target setting that the Department of Health itself has admitted is sometimes excessive. Although government action has not always helped, similar tensions seem to exist in other systems in which government plays a much less

See end of article for author's affiliation

Correspondence to: Mr N Edwards, NHS Confederation, 1 Warwick Row, London SW1E 5ER, UK; nigel.edwards@nhsconfed.org

other parts of the economy and are less tolerant of the badly organised, disjointed, and consumer unfriendly services that are all too common in health care. This challenges autonomy because it requires aspects of clinical work and associated activities such as scheduling, clinic organisation, follow up, and communication to be made more systematic and standardised.

Perhaps the most significant challenge to the traditional idea of autonomy has come from the medical profession itself in response to evidence for huge variations in practice, the continued use of practices known to be ineffective or even harmful, and the failure to adopt effective practice.⁷⁻⁹ Davies and Harrison argue that there has been a shift in the epistemological basis of medicine from one based on tacit understanding, professional consensus, and reflection to a more scientific-bureaucratic model in which the emphasis is on the use of evidence and, where appropriate, the systemisation of work,¹⁰ which is known to improve outcomes.^{9 11-14}

Systemisation of work has also been used as part of a much more explicit emphasis on the role of the physician in containing costs. The interest of policy makers in evidence-based medicine, for example, was in part motivated by the hope that it would reduce costs and improve effectiveness. Guidelines, protocols, and the use of information to feedback utilisation data to clinicians were also hoped to have the same effect.

Why should a decline in autonomy and an increased emphasis on accountability represent an attack on the psychological contract and create so much resistance? Research by Degeling *et al* in the United Kingdom, Australia, and New Zealand suggests that it is because doctors are socialised into a set of beliefs and approaches that are in opposition to these changes. Their work also starts to shed light on why relationships with managers can be difficult. Doctors, managers, and nurses differ in their views on five key dimensions.¹⁵⁻¹⁷

- Accountability *v* autonomy: whether they ascribe to accountability to others or personal autonomy.
- Clinical purists *v* financial realists: whether they accept that all clinical decisions have resource implications and that this matters. Doctors tend to resist the intrusion of financial issues into clinical decision making.
- Systemisation of clinical work: whether this is seen as appropriate—nurses and managers tend to support this view, doctors to reject it.
- Individuals *v* collectives: unsurprisingly and appropriately, doctors tend to consider the individual patient whereas those in management positions are more likely to think in terms of groups.
- Power: doctors tend to reject the idea that the power sharing implied by team working is appropriate, nurses and managers tend to be more positive.

The growth of accountability and decline in autonomy is therefore a direct assault on the deeply held beliefs of some doctors. Worse, they are being asked to take rationing decisions—a concept that they do not accept, using systemisation methods, which they tend to reject. Just to add insult to injury, they are then asked to share power with other professionals and managers and join teams, both of which many are at least equivocal about. Managers may have the misfortune to be seen as the embodiment of a number of malign influences undermining medicine as it was meant to be practised.

It is important to stress that the research does not imply that this is the view of all doctors. Indeed, only a minority would strongly subscribe to all the aspects of the extreme form expressed here and many do accept the idea of team

working, taking financial responsibility, making work more systematic, and being accountable. There are, however, few incentives to speak up in favour of these ideas and some considerable risks.

These data explain why many doctors seem to say that their managers do not understand their work. There are aspects of the way that management operates that do not help either. Mintzberg and Glouberman suggest that there is a disconnection in the hierarchy in healthcare organisations; the work of managers does not connect to the work of front line staff as it does in many other non-healthcare organisations.¹⁸ There are two reasons for this. Firstly, there has been a lack of acceptance of the legitimacy of management to be involved in the detail of clinical work and lay managers or even medically qualified managers lack the expertise to do this. This means that management has often been occupied with issues tangential or even unrelated to the practise of medicine, for example in the running of administrative systems. More recently they have become increasingly engaged in indirect attempts to influence medicine through the use of incentives, employment contracts, and structural reorganisation. Secondly, managers are required to focus outside the organisation either on the requirements of government or local politicians or in market systems on those of investors. Both groups have objectives and values that will not necessarily coincide with those of doctors focused on the single patient.

In the United Kingdom a particular issue seems to be high levels of management turnover compared with consultants, who tend to spend their entire career in one place. Turnover of chief executives of acute hospital trusts in England has been over 22% in the past three years compared with 7.5% in non-finance quoted companies. This makes the development of good relationships more difficult and consultants may be suspicious that the commitments made by one group of managers may not be honoured by the next. High turnover and the operation of a very short term annual cycle for planning and decision making may exacerbate a culture of short termism in management. The perception that some of the high turnover of managers is due to the influence of government is a further problem. Firstly, there is a concern that even if a good relationship exists with the current management they may be replaced with others more amenable to the views of government. Secondly, it makes clinicians less likely to become managers themselves, as the job appears to be unattractive and risky. Thirdly, it casts chief executives in the role of middle managers required to implement the vision set by others and focusing on the needs of those above them rather than acting as a “servant leader” to those below them—a role that many in the National Health Service (NHS) would seem to prefer. This inhibits the development of motivation around a vision for the organisation that local staff and managers could share and work towards. Perhaps of most concern for the quality and safety of health care is that seeing senior people treated in what is often a quite brutal way may have a deleterious effect on staff that remain. There are already relatively high levels of bullying and intimidating behaviour within and between different staff groups in health care, and having these implicitly sanctioned at the highest level is unhelpful.^{19 20} There is good evidence that high quality relationships seem to produce higher staff satisfaction and improve outcomes for patients.^{11 13 21 22} They also create an environment in which error reporting is easier and more common.²³ It seems likely that organisations characterised by stress, fear, high turnover, bullying, and other sequelae of poor relationships will be doing their patients and staff positive harm and that, *ceteris*

paribus, there will be measurably higher mortality rates, near misses, and staff and patient accidents.

A further reason for poor relationships that is often cited by doctors is the alleged background and poor calibre of managers in health care:

“Many of the managers in the NHS are there by default. They do not have the intellectual ability to genuinely see the differences between hospitals and supermarkets or doctors and checkout cashiers. They are the pass GCSE students. Remember them at school?”²⁴

There seems to be limited evidence for this view and in fact recent studies by Alimo-Metcalf²⁵ and the Hay Group for the Department of Health²⁶ suggest that senior managers in the NHS seem to compare well to their opposite numbers in industry and other sectors.^{27–28} It may be that the complexity of health care means that this is not good enough. In fact, most managers come from within health care and in a recent survey 27% of English chief executives had a clinical background.

There is no equivalent evidence about the calibre of middle managers—a group that is subject to particular criticism by doctors in the United Kingdom medical press. What is clear from studies in the United Kingdom and Australia is that this group have a very difficult task in balancing the requirements of those above them with the demands of their job and the need to sustain a relationship with their medical colleagues. In fact, these studies seem to show that it is this group who are displaying most signs of stress. It may be that doctors’ training, strong sense of personal identity, and the fact that they identify with a profession or peer group outside the organisation means that they are more protected from emotional buffeting of this sort. In the United Kingdom study middle managers had levels of stress and minor psychiatric disturbances that were significantly greater than the average for the population as a whole and higher than other staff groups, with female managers fairsing worst.²⁹ This is likely to diminish managers’ effectiveness and add to a credibility problem that they may have with some doctors because of their junior position.

DISCUSSION

Poor relationships between doctors and managers affect staff and patients’ care and seem to be associated with the long term failure of organisations to thrive.³⁰ Many of the reforms to health care envisaged in *Crossing the quality chasm*,⁸ *The NHS plan*,³¹ or other manifestos for change will be impossible without high levels of clinical engagement in the work of the organisation.

This is an area that would benefit from more research but a number of ideas seem to be worthy of further exploration.

Work to improve relationships

Mutual respect for differences, taking care of each other, and avoiding falling victim to stereotypes seems important. Organisations may have to positively work to develop this through agreed rules of behaviour (about, for example, integrity, keeping promises, avoiding personal attacks), principles for decision making—particularly in difficult areas such as resource allocation or ethical dilemmas, and through continuous discussion, negotiation, and interaction. Longevity in top management teams and attention to the quality of middle management are important to support the development of these relationships. Experience also suggests that managers and clinicians need to be able to develop mission, goals, objectives, and strategies for their organisation that are aligned with those of the clinicians.³² This means external intervention, target setting, or the centralisation of

these decisions needs to be carefully handled to avoid disrupting local relationships.³³

Managers do need to learn more about medicine and doctors would benefit from learning management tools and techniques,³⁴ however, mutual understanding is not the same as trying to make one group see the world the same way as the other, which is the tone of many of the recommendations in this area.

Develop common approaches

Finding a common approach to managing resources, accountability, autonomy, and the creation of more systematic ways of working seems to be important. The use of costed clinical pathways can help to find a way of translating between medical and managerial views and overcomes the problem that much management discourse is about issues other than patient care. Acknowledging the reality that clinicians are asked to take rationing decisions rather than pretending these do not exist may be important.

Redefine not abolish the idea of autonomy

Rather than seeing guidelines and accountability systems as a threat to autonomy, there is an argument that they are an essential adjunct. Autonomy is not tenable without some form of accountability, the expectations of the public and regulators and simple common sense require that freedoms are balanced with responsibilities, including reporting results and explaining one’s actions. Responsible autonomy is essential. The reason for extended professional training is precisely so that doctors know when and how to exercise autonomy and depart from the pathway. Degeling suggests the answer to the question “do I have the right to depart from the pathway?” is “not just a right, you have a duty to do so” (personal communication April 2003). The key is that it should be documented and the reasons for variance understood.

A second component of this strategy is helping doctors regain some of the control they have lost over their working lives in organisations. It is well known that low levels of control over one’s job and poor social support are associated with stress and even with higher mortality.^{35–36} Doctors receive very little training or support to equip them to deal with organisations and in the United Kingdom may not really encounter organisational life until they are consultants. Training doctors more systematically in management, organisational, and team working skills might help to address the paradox that members of this most powerful profession often feel impotent in the face of unfathomable bureaucracies. Making the bureaucracy easier to navigate would also help.

Create clinical leadership

Strong and high quality clinical leadership and working in partnership with managerial colleagues seems to be a key element of improved relationships and of organisational success.^{20–37} Winyard argues that management has intruded into areas that have not been dealt with by the profession in the way they should if it had appropriate systems of self regulation.³⁸ Doctors and clinical leaders are in a pivotal position to do this and to form a key link between the two groups. They also have an important role in providing leadership, creating shared purpose, and building the relationships necessary for success with their clinical colleagues. Improving clinical leadership requires earlier and better training of doctors in management and leadership, action to make clinical leadership jobs more attractive, and support for clinical leaders in what is often one of the most difficult jobs in health care.

CONCLUSION

The recurring themes of the proposed solutions are about the need to pay direct attention to underlying values and beliefs

Key messages

- Many of the new ways of working quickly run into problems with clashes between managers and doctors about the way organisations work.
- Many of the tools of quality improvement and safety run the risk of being seen as part of a managerial world that is associated with changes in society and health care that many doctors are uneasy about.
- Good relationships in organisations seem to be associated with improved outcomes for patients and it seems equally likely that poor relationships between doctors and managers may have a direct impact on patient care.
- Explicit attention should be given to finding ways to repairing and renegotiating these key relationships.
- Clinical leadership is of key importance to this enterprise.

held by both sides and to issues of honesty, trust, mutual respect, and relationships. These are very often ignored as organisations focus on the tasks to be undertaken or problems they face and do not have time for these “soft” issues. This runs the risk of mistaking the urgent for the important. A failure to fix these problems inside the organisation may prevent progress on any other issue.

The viewpoints of doctors and managers are different and this is inevitable and not necessarily undesirable. What is important is that the reasons for these differences are properly and appreciatively explored and understood. This will mean having some difficult conversations and confronting bad behaviour and both sides will need to change to accommodate the other. Work on this is in hand in the United Kingdom.³³ This seems urgent, important, and is perhaps the most challenging problem in improving health care.

Author's affiliation

N Edwards, NHS Confederation, 1 Warwick Row, London, SW1E 5ER, UK

REFERENCES

- 1 Smith R. Why are doctors so unhappy? There are probably many causes, some of them deep. *BMJ* 2001;**322**:1073–4.
- 2 Edwards N, Kornacki MJ, Silversin J. Unhappy doctors: what are the causes and what can be done? *BMJ* 2002;**324**:835–8.
- 3 Davies HTO, Hodges C-L, Rundall TG. Views of doctors and managers on the doctor-manager relationship in the NHS. *BMJ* 2003;**326**:626.
- 4 Silversin J, Kornacki MJ. *Leading physicians through change: how to achieve and sustain results*. Tampa, FL: American College of Physician Executives, 2000.
- 5 Ham C, Alberti KGMM. The medical profession, the public, and the government. *BMJ* 2002;**324**:838–42.
- 6 Mechanic D. How should hamsters run? Some observations about sufficient patient time in primary care. *BMJ* 2001;**323**:266–8.
- 7 Wennberg JE, Barnes BA, Zubkoff M. Professional uncertainty and the problem of supplier-induced demand. *Soc Sci Med* 1982;**16**:811–24.
- 8 Institute of Medicine. *Crossing the quality chasm*. Washington DC: National Academy Press, 2001.
- 9 Jencks SF, Cuedon T, Burwen DR, et al. Quality of medical care delivered to Medicare beneficiaries: a profile at state and national levels. *JAMA* 2000;**284**:1670–6.
- 10 Davies HTO, Harrison S. Trends in doctor-manager relationships. *BMJ* 2003;**326**:646.
- 11 Gittel JH, Fairfield KM, Bierbaum B, et al. Impact of relational coordination on quality of care, postoperative pain and functioning, and length of stay: a nine-hospital study of surgical patients. *Med Care* 2000;**38**(8):807–19.
- 12 Griffin S, Kinmonth AL. Diabetes care: the effectiveness of systems for routine surveillance for people with diabetes. *Cochrane Database Syst Rev* 2000;(2):CD000541.
- 13 Shortell SM, Jones RH, Rademaker AW, et al. Assessing the impact of total quality management and organizational culture on multiple outcomes of care for coronary artery bypass graft surgery patients. *Med Care* 2000;**38**(2):207–17.
- 14 Shortell SM, Bennett CL, Byck GR. Assessing the impact of continuous quality improvement on clinical practice: what it will take to accelerate progress. *Millbank Q* 1998;**76**:593–616.
- 15 Degeling P, Maxwell S, Kennedy J, et al. Medicine, management, and modernisation: a “danse macabre”? *BMJ* 2003;**326**:649–52.
- 16 Degeling P, Kennedy J, Hill M. Mediating the cultural boundaries between medicine, nursing and management—the central challenge in hospital reform. *Health Serv Manage Res* 2001;**14**:36–48.
- 17 Degeling P, Sage D, Kennedy J, et al. A comparison of the impact of hospital reform on medical subcultures in some Australian and New Zealand hospitals. *Aust Health Rev* 1999;**22**(4):172–88.
- 18 Mintzberg H, Glouberman S. Managing the care and cure of disease – part I: differentiation, part II: integration. *Health Care Management Review*, (Winter), 56–86.
- 19 Kassebaum D, Cutler E. On the culture of student abuse in medical school. *Acad Med* 1998;**73**:1149.
- 20 Crosson FJ. Kaiser Permanente: a propensity for partnership. *BMJ* 2003;**326**:654.
- 21 Aiken LH, Sloane DM, Sochalski J. Hospital organization and outcomes. *Qual Heal Care* 1998;**7**:222–6.
- 22 Shortell SM, Zimmerman JE, Rousseau DM, et al. The performance of intensive care units: does good management make a difference? *Med Care* 1994;**32**:508–25.
- 23 Edmondson A. Learning from mistakes is easier said than done: group and organisational influences on the detection and correction of human error. *J Appl Behav Sci* 1996;**32**:5–28.
- 24 Fahy G. Consultant's Contract, no mistake or mistake: there is treachery in your midst. eBMJ <http://bmj.com/cgi/eletters/325/7355/99#24393> (rapid response).
- 25 Alimo-Metcalfe B, Alban-Metcalfe J. Stamp of Greatness. *Health Service Journal* 2003 June;**26**:28–31.
- 26 Department of Health. *NHS leadership qualities framework*. London: NHS Leadership Centre, 2002.
- 27 Dahya J, McConnell J, Travlos N. *The Cadbury Committee, corporate performance and top management turnover*. Cardiff: Cardiff Business School, Cardiff University, 2000.
- 28 Mooney H. Chief executives leave at a worrying rate. *Health Service Journal* 2003;**6**.
- 29 Wall T, Bolden R, Borrill C, et al. Minor psychiatric disorder in NHS trust staff: occupational and gender differences. *Br J Psychiatry* 1997;**171**:519.
- 30 Protoplati G, Fulop N, Edwards N, et al. *Failure and turnaround: dealing with failing hospitals*. London: NHS Confederation, 2002.
- 31 The Stationery Office. *The NHS plan. A plan for investment. A plan for reform*. Cm4184. Norwich: The Stationery Office, 2000.
- 32 Shortell SM, Alexander JA, Budetti PP, et al. Physician-system alignment: introductory overview. *Medical Care* 39(7)(Suppl):1–8.
- 33 NHS Confederation. *Medicine and management: improving relations between doctors and managers*. London: NHS Confederation, 2003.
- 34 Smith R. What doctors and managers can learn from each other. *BMJ* 2003;**326**:610.
- 35 Stansfeld SA, Fuhrer R, Shipley MJ. Types of social support as predictors of psychiatric morbidity in a cohort of British Civil Servants (Whitehall II Study). *Psychol Med* 1998;**28**(4):881–92.
- 36 Bosma H, Marmot MG, Hemingway H, et al. Low job control and risk of coronary heart disease in whitehall ii (prospective cohort) study. *BMJ* 1997;**314**:558.
- 37 Firth-Cozens J, Mowbray D. Leadership and the quality of care. *Qual Saf Health Care* 2001;**10**(Suppl II):ii3–7.
- 38 Winyard G. *Doctors, managers and politicians*. 2003 Milroy Lecture at the Royal College of Physicians (in press).