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EDITORIALS

CHRISTMAS 2012: EDITORIAL

When managers rule

Patients may suffer, and they're the ones who matter

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Written by the managing director of Sainsbury's supermarkets, and three other businessmen, the "Griffiths report" (1983)[1] unleashed a management revolution in the NHS. The report's key recommendation were for a supervisory board to overview policy and strategy and a management board to implement it, together with regional, district, and unit general managers. In 2008, with the revolution well and truly over, the *Health Service Journal* ranked Roy Griffiths 12th in its list of the 60 most influential people in the NHS's history for his role in setting NHS management on its current path.

After the report's publication, the administrator of our district management team said something like "we will run the show from now on." This was despite Griffiths' recommendation that, consistent with clinical freedom for clinical practice, clinicians should be involved more closely in management and participate fully in spending decisions. At the time, Manfred Davidmann, who comments on styles of management, put his finger on one of the report's problems: "What is completely missing from the inquiry team is grass-roots representation of any kind from all those who would be affected by the inquiry's findings, namely from doctors, nurses . . ." He also correctly predicted how the new "managerialism" would play out over the next 30 years: "Management (that is executives) are apparently to provide patients and the community with what management and higher authority think is good for them."[2]

My contention is that the imbalance between the power of managers and doctors, which Griffiths set in train, is harming patients. This imbalance of power plays out in many ways. Managers, who do not have an ethical or regulatory body equivalent to the General Medical Council, can report a doctor to the GMC, and even if the GMC finds no fault with the doctor's behaviour, the doctor may still find it difficult to get another job in the NHS. There is little or no opportunity for redress in terms of the manager's behaviour.

Doctors, who—after going unsuccessfully through the appropriate internal channels—publicly complain about situations that they consider compromise patient safety, have occasionally been dismissed by their hospital trust.[3] If an employment tribunal finds that a doctor, or other member of staff, was wrongfully dismissed or treated badly by the trust, that doctor may have considerable difficulty obtaining further employment in the NHS.[4]

The GMC advises doctors to "take independent advice on how to take the matter further" if trusts take little or no action about their concerns.[5] However, although professional help is available, doctors may still have difficulty finding "independent advice" without potential detriment to their future employment in the NHS. A whistleblower emailed me in 2010 to say "At present, if you whistleblow, you will be dismissed—it's as simple as that! . . . Once doctors are dismissed, it is virtually impossible to find employment back in the NHS." The cost of defending a wrongful dismissal can be high, and the doctor may have to sign a gagging clause to get any compensation from NHS organisations.[6]

A BMA survey showed that more than half of doctors surveyed had concerns about standards of patient care in their workplace, and some of those who reported their concerns agreed that: "The trust indicated to me that, by speaking up on sensitive issues, my employment could be negatively affected."[7]

Currently managers may sit on, or chair, clinical excellence award committees that advise about recommending doctors for awards.[8] Managers can have considerable influence on the funding of units and appointments to posts within a hospital.

At the national level the managerial influence may come from higher up the NHS hierarchy. Units within royal colleges and other national healthcare organisations may be funded partially by grants from the Department of Health, which has significant power of patronage in terms of recommending doctors for national honours.

In 2007, the Department of Health in England commissioned three reports on the regulation of the NHS from three respected US organisations—the Institute for Healthcare Improvement (IHI), the Joint Commission International (JCI), and Rand Corporation.[9] JCI is the international branch of the Joint Commission, which accredits and certifies more than 19 000 healthcare organisations and programmes in the United States.

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These reports were submitted to the Department of Health in January and February 2008 but were not published or referred to by the House of Commons Health Select Committee when it debated patient safety in 2009.[10] They were released in January 2010 only as the result of a Freedom of Information Act request. The IHI report says: "The NHS has developed a widespread culture more of fear and compliance, than of learning, innovation and enthusiastic participation in improvement." It also said "Virtually everyone in the system is looking up (to satisfy an inspector or manager) rather than looking out (to satisfy patients and families)" and "managers 'look up, not out.'"

The IHI report states: "We were struck by the virtual absence of mention of patients and families in the overwhelming majority of our conversations, whether we were discussing aims and ambition for improvement, ideas for improvement, measurement of progress, or any other topic relevant to quality." The JCI report says "A 'shame and blame' culture of fear appears to pervade the NHS and at least certain elements of the Department of Health." It also says "This culture is affirmed by Healthcare Commission leaders who see public humiliation and CEO [chief executive officer] fear of job loss as the system's major quality improvement drivers. Although it found "an emerging aspirational tone across the Department of Health ('world class commissioning,' 'clinical excellence pathways'),," there were "few indications of sufficient attention being paid to basic performance improvement efforts."

These reports were largely dismissed by the Department of Health witnesses to the Mid Staffordshire Public Inquiry. The department's permanent secretary and its counsel described the IHI and JCI reports as "caricatures."[11 12] The inquiry counsel stated that "David Nicholson [chief executive of the NHS] told the inquiry that he didn't believe the JCI report was significant. Indeed, in general, the department witnesses did not accept or even recognise some of the criticisms contained in the American reports, and yet many of those criticisms of a top-down and bullying culture were described by witnesses to the inquiry."[13] However, the Department of Health acknowledged that those interviewed for the reports—who included Bruce Keogh (medical director, Department of Health), Nigel Crisp (ex-chief executive, NHS), Ian Kennedy (ex-chairman, Healthcare Commission), Andrew Dillon (chief executive of the National Institute for Health and Clinical Excellence), Bernard Crump (ex-chief executive West Midlands strategic health authority), Sally Davis (chief medical officer, Department of Health, England), Martin Fletcher (chief executive, National Patient Safety Agency), and Niall Dickson (chief executive and registrar, GMC)—might be taken seriously.[14 15]

The BMA was established "To promote the medical and allied sciences, to maintain the honour and interests of the medical profession and to promote the achievement of high quality healthcare."[16] Emasculation of the medical profession by over-powerful managers or "Stalinist" control from the centre could hinder attempts to improve patient care.[17 18] Making it difficult for doctors to whistleblow could be detrimental for patient care. The primary consideration should be: what is best for patients?

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