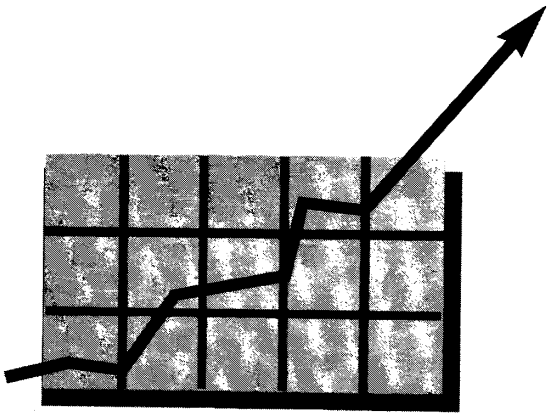
DOCTORS
AS MANAGERS
OF CLINICAL RESOURCES

EDITED BY JO IVEY BOUFFORD



REPORT OF A WORKING CONFERENCE ON
MANAGEMENT DEVELOPMENT

DUBLIN, 16–18 MAY 1993

European
Healthcare
Management
Association

DOCTORS as MANAGERS

OF CLINICAL RESOURCES

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Sponsored by the European Healthcare Management Association

Conference Co-Directors:
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Contents

List of participants

Country co-ordinators

England & Wales	David Schofield Stephen Prosser Norman Mills
Finland	Taina Mantyranta
France	Dominique Deugnier Philippe Duprat
Germany	Friedrich Wilhelm Schwartz Heinrich Kochs Matthias Klein-Lange
Ireland	Marie Brady Luke Clancy Austin Leahy
Israel	David Chinitz
Italy	Andrea Francesconi Antonello Zangrandi Carlo Ramponi Luciano Beolchi
The Netherlands	Aad de Roo Hans Van Dyke
Scotland	Robin Knill-Jones
Spain	Jose Repullo
Sweden	Kerstin Sjoberg Johan Calltorp Eric Paulson

Conference facilitators

Philip Berman, European Healthcare Management Association
Jo Ivey Boufford, King's Fund College, London
Laraine Joyce, Institute of Public Administration, Dublin
John Mitchell, King's Fund College, London

Conference administrators

Breeda Doyle, Institute of Public Administration, Dublin
Rena Dooley, European Healthcare Management Association

Introduction

Most would agree that the decisions of doctors about the use of clinical resources, whether in the hospital or the primary care/community setting, are critical factors in the cost of any health care system. Decisions on the number of visits patients have, whether or not they are admitted to hospital and how long they stay, as well as the numbers and the types of tests, specialty consultations, and procedures ordered, are largely determined by doctors.

While historically a doctor's major concern has been the needs of the individual patient, it has become increasingly important that doctors understand the cost implications of their decisions, not only for the individual patient but also for the resources available to other patients, and for the financial viability of practices, provider units and the health care system as a whole.

Resources are not the only concern. Increasingly, concerns over the quality of care, including high levels of variability in the quality and type of services provided in response to what appear to be the same clinical needs, are placing new pressures on doctors to review critically their own practice and, often, be subject to review by outside agencies.

Over the past several decades, there has been a growing feeling that an effective way of bringing about change in the behaviour of doctors, in order that they address these and other issues facing the health care system, is by introducing them to concepts of management, and increasingly, involving them directly in the management of clinical services. The European Healthcare Management Association (EHMA) is committed to the development of more effective health care policy-making and health care management. In most countries, doctors are playing an increasingly important role in health care management, and many member organisations of EHMA are involved in helping to develop these doctors' management capabilities. Three years ago, the EHMA Board initiated a series of activities to 'determine best practice in the provision of health care management development programmes for doctors'.

In 1990, a special edition of the *EHMA Newsletter* was devoted to a detailed compendium of the existing management development programmes for doctors that were being provided by EHMA members.

In the annual meetings over the next two years, workshops were held on this topic, and at the Karlstad meeting in 1992, it was decided to hold a working conference with the maximum possible representation from management development centres across Europe to explore these complex issues.

The first task was defining the focus for our work. In some countries, doctors have always been or are increasingly involved in so called 'general management' posts – as hospital directors or general administrators – where their clinical background may be useful but not necessary. Whether individuals holding these jobs are doctors or economists or engineers, the key is *their ability to manage complex institutions*. The general consensus is that the management training for such doctors should be the same as for other general managers. By contrast, this project has focused primarily on doctors as managers of clinical resources; these individuals often continue to be clinically active while exercising a management role. The specific goals of the project were to:

- understand the similarities and differences between participating countries in the roles of doctors in the management of clinical services;
- understand and assess the strengths and weaknesses of the current approaches to management development for doctors;
- identify the major issues facing those organisations which seek to provide management development services to doctors;
- recommend ways forward to strengthen future management development for doctors in clinical services.

The project sought to accomplish these goals through the preparation of a position paper for each participating country, using a relatively standard framework, followed by a working conference to consider the issues raised in the papers.

This conference was held in Dublin, on 14–16 May 1993. Papers prepared for the conference were revised over the summer of 1993, and the conference summary was written by the conference co-directors and circulated for comments to participants. Publication has been made possible by a grant from The King Edward's Hospital Fund for London.

management of clinical resources in particular, and the health care delivery system in general, is one of the most crucial faced by health sector leaders in every country. We hope this volume will contribute to progress in this important area.

CONFERENCE SUMMARY

In May 1993, representatives of ten countries met for two days in Dublin, under the auspices of the European Healthcare Management Association (EHMA), to explore similarities, differences, and potential ways forward to strengthen management development for those doctors managing clinical resources. Prior to this working conference, the co-ordinators from each participating country had produced a paper examining the state of management development for doctors in their respective country, and identifying strengths and weaknesses in the approaches currently in use; they were also asked to speculate on possible future directions for this work.

Each country had been asked, if possible, to identify a team of 2–3 individuals to participate in the conference, including those with considerable experience in delivering management development programmes for doctors, and a doctor who could critically analyse his or her experience as a client for such a programme. Four countries were represented by a single individual, in all cases a provider of management development programmes, while seven fielded a team including the 'target audience' for our work. The countries represented were: Great Britain (England and Wales, and Scotland produced two separate papers, due to the differing pace of the health care reform process in different parts of the UK), Finland, France, Germany, Ireland, Israel, Italy, The Netherlands, Spain and Sweden.

The design of the meeting was highly participative, taking the papers as a starting point. Initial sessions were designed for participants to become acquainted with the frameworks of each other's health care systems, the particular roles of doctors in management, and the general approaches being used in management development for doctors. The rest of the meeting was spent trying to go underneath the surface and, as one participant put it, 'to understand the reality behind the descriptions'. From this better understanding, several common themes emerged and a number of issues that need to be addressed were identified. While the approaches being used in each country were unique, it often felt as if there was a basic 'medical culture' that allowed us to communicate in an almost universal language.

THE NEED FOR FUNDAMENTAL CHANGE

The strongest message from our work together is that the changes facing doctors and the medical profession are profound in virtually every country, and that they are inescapable. Most countries represented are either in the middle of, or contemplating, major health system change. The most common reason is governmental concern about the growing cost of the health care system in times of economic stringency. A consequence of this concern in many countries is the introduction of greater managerial and public accountability for resource use. This public accountability can be seen at a societal level, as 'the public' or 'community' seeks a role in decision-making about overall resource use and, at the individual patient level, where the doctor's word is no longer automatically accepted without question.

Within the health care delivery system itself, other pressures for change are felt to a different degree in each country – trends to shift services from hospitals to community-based settings; greater emphasis on quality assurance and outcome-oriented approaches to evaluating effectiveness; the increasing visibility and assertiveness of nurses, therapists and other health professionals, eager to play a greater role in the health care team.

The consequences of all these changes fall heavily on the medical profession. The strongest feeling is one of a shifting of power in new directions – from hospital specialists to hospital managers; from hospital-based doctors to general practitioners and other primary care doctors; from doctors to other health professionals; and from doctors to patients. The common denominator is a relative loss of power by all doctors, but especially hospital-based ones, traditionally the most clinically autonomous and managerially independent of the other segments of the health care system.

The perception of these changes and the degree to which they are seen as either a threat or an opportunity for the medical profession, varies from country to country. All agreed that withdrawal from the change – hoping that it will go away – is not a viable option, and most doctors realise this. The medical profession's reactions vary along a continuum from organising to resist any change, to trying to understand the reasons for the change, to taking part in the change, to trying to lead it. As providers of management development for doctors in the clinical arena, we all feel ourselves to be in the middle of this change process, and try to

respond to the needs of doctors who are at varying points along this continuum.

Three major areas were identified for more in-depth discussion:

- the priorities for management development of doctors;
- preparing doctors for their different professional/managerial roles as managers of clinical resources;
- motivating doctors to be interested in management issues and management development.

The discussions are summarised here in the hope that they may strengthen our potential to respond to the needs of doctors, and help them play a positive role in health care delivery systems as they attempt to meet the needs of the populations they serve.

WHAT ARE THE PRIORITIES FOR MANAGEMENT DEVELOPMENT?

It is clear that the answer to this question depends very much on who is being asked. There are very different 'stakeholders', often with quite conflicting views on the issue of involving doctors in management of clinical resources.

We identified four key stakeholders:

- the patients/consumers
- the individual clinicians themselves
- their employers (government/management)
- the providers of management development programmes.

While we recognise that a true 'stakeholder analysis' must be done locally to inform any management development design process, our joint work identified the following:

What do patients want?

- Access to services (including availability in time, place, and cultural relevance).

- Courtesy – to be respected as individuals.
- Quality – to know who is responsible, and understand their rights, choices, and the risks and constraints of the proposed treatment.
- Responsiveness to complaints – to have clear recourse for dissatisfaction and, if necessary, advocacy to pursue malpractice.

What do clinicians want?

- To get adequate resources to enhance their patient care, research, prestige, or income (there are mixed motivations here).
- To perform well.
- To retain their power.
- To have colleagues' respect.
- To safeguard their institution and their jobs.
- To resolve anxieties about managers and management by understanding the context of their organisation and the proposed change, and developing a common language with managers.
- To get actively involved in management and influence the process.
- To get actively involved in management to defend the profession.

What do the 'employers' want?

GOVERNMENT

- An acceptable level of health care in return for the resources invested.
- Cost containment.
- No scandals.
- To contain the influence of the medical profession.
- To distance government from difficult decisions.

MANAGEMENT

- To stay within their budgets.
- To control doctors.
- To obtain good medical advice for decision-making.
- To maintain 'social peace' in the human resources area.
- To get doctors to share appropriate responsibility for strategy and managerial decision-making.

- To develop a greater sense of shared values and mutual trust with doctors.
- To empower doctors properly.
- To balance clinical autonomy with the mission of the organisation.

What do providers of management development want?

- Financial viability.
- To fulfil their stated institutional purposes and/or respond to government mandate.
- To (be seen to) succeed.
- To be relevant and needed.
- To have facilitated a major change process.
- To empower all the key players, including patients.
- To make doctors more effective participants in the health care system.

In conclusion, it is very important that providers of management development programmes for doctors conduct a very careful analysis of the priorities of the different stakeholders in each setting before developing their approach to management development. It was also suggested that stakeholders actually be involved in the developmental process, not just consulted as it begins.

PREPARING DOCTORS TO MANAGE CLINICAL RESOURCES

Two groups approached, from different perspectives, the issue of preparing doctors for their different managerial/professional roles in managing clinical resources. One looked at the actual roles that doctors play at different levels in the health care delivery system and their key responsibilities. The other looked at the potential opportunities for, and preferred approaches to, management development for doctors along the continuum of medical education and practice. Both are areas of considerable variability from country to country and of significant controversy, especially regarding training models. While there was

insufficient time to debate the work of each group, certain areas of clear agreement and disagreement did emerge.

Both groups began by developing a broad framework for their discussions – one for educational models, and the other for the professional responsibilities and roles of doctors managing resources at different levels.

Management responsibilities

The group exploring actual work responsibilities identified several levels at which doctors formally manage clinical resources, each one with its own demands and management development needs.

ROLES AT HEALTH POLICY LEVEL OR WITH PURCHASERS

- Working within available resources (total costs).
- Assisting in formula development for resource distribution (overall equity).
- Advising on priorities for expenditure (rationing).
- Assessing health need (population orientation).
- Assuring efficiency (unitary costs).
- Developing a framework for quality (effectiveness).
- Relating to political environment.

ROLES AT PROVIDER UNIT LEVEL

- Unit level medical leadership.
- Participating in strategy.
- Allocating resources to departments.
- Setting standards for and monitoring:
  (i) how many (quantity)
  (ii) how good (technical quality)
  (iii) how much (cost-effectiveness)
  (iv) how acceptable (patient satisfaction).
- Mediating competing interests.
- Helping develop corporate approach.
- Relating to outside environment.

Roles at department or service level

- Department level medical leadership.
- Optimising resource acquisition and use.
- Setting departmental standards and monitoring (see variables (i)–(iv) as noted above).
- Specific technical expertise in service area.
- Managing educational programmes.
- Building management team.
- Managing 'out' across departments and 'up' to unit level.

Roles at clinical level

- Awareness of organisational context for practice.
- Maximising effectiveness of own practice.
- Making efficient use of own time.
- Putting the patient first.
- Collaboration/communication with medical and other colleagues.

Roles at trainee level

- As with clinical level, appropriate to the degree of autonomy and responsibility delegated.

Educational models

The group which began to work on training models along the educational and practice continuum, identified two alternative approaches to the introduction of management principles at undergraduate medical education level. The first approach considers expanding existing curricula by integrating, whenever possible, the following key managerial concepts: communication, health economics/cost, IT, the context for medical practice, time and stress management, social medicine. The difficulties of this approach were acknowledged, but given the 'crowding' of the medical school curriculum, such thoughtful integration seemed the most promising way forward during the early years. The second approach, that of introducing a specific course in management of clinical resources, was seen as most

practical in year 4–5 when the student has developed some curiosity about the bigger picture. The focus should be on organisational behaviour, financial management, decision-making, and quality-assurance methods.

Most felt that it was critical that much of the teaching at the undergraduate level be done by doctors or by a team including a doctor, as the 'role model' effect is critical for students.

For doctors at other levels on the continuum, the programmes should reflect their perceived needs and those of other stakeholders. There should be a flexible and varied approach to teaching methods: most doctors appear more comfortable initially with didactic methods, familiar to them from their medical education. However, it is crucial to move beyond 'lecture/discussion' formats and introduce case studies, problem-based learning, on-the-job and off-the-job approaches, and 'action-learning' techniques in which small groups explore and learn from each other's experience – initially, with the help of a trained facilitator and, eventually, on their own.

An area of considerable debate concerned the choice of faculty for such training. Most agreed that a team approach involving a doctor at or above the level of the particular 'trainees', together with a professional management development consultant, would be appropriate in most instances. The involvement of non-doctor health professionals in management development of doctors, and the training of doctors in inter-disciplinary groups with other health professionals or students were, in principle, to be encouraged. There was a concern by some that doctors at whatever level had to be secure enough in their own identity to gain from inter-disciplinary programmes and to take risks in front of non-doctor colleagues.

There was a strong consensus that management principles need to be introduced throughout the continuum of medical education. There might be grounds for the development of a new 'theory of medical or health professions management' or, at least, a systematic effort by management development practitioners and academics to test commonly accepted and taught theories of management against the realities found in the health care delivery system. Others saw such an approach as potentially exclusionary and isolationist – once again doctors and health professionals might separate themselves by saying 'we're different', and therefore not subject to other norms and patterns.

The role of incentives to encourage doctors to integrate management principles and practice into their education and clinical work was emphasised – whether it was through increasing the availability of time, money, or other less tangible institutional rewards and recognition. At present, in most countries, there is very little reward or support from colleagues for doctors who express an interest in management, and even less for those who would take part. This is a critical factor in motivating doctors to be managerially aware or active.

MOTIVATING DOCTORS

Doctors are motivated to learn about or take up management for quite different reasons. While some doctors continue to focus on the care of their individual patients and are oblivious to the changes in the world around them, these are few in number. Most find themselves in the middle of dramatic changes that seem to be brought about by something called 'management', which they do not understand. Some are naturally attracted to management as it appears to give them wider scope for influence, or see it as a way out of a career crisis – for example, where clinical practice has lost its attractions; while others want to use management principles to fight back and defend their territory.

There was general agreement that all doctors should be encouraged to, at least, take an interest in the managerial issues that affect their own patient practice; and, from there, that it would be critical to identify that smaller group of doctors who may, in fact, be motivated to play a greater role as managers of clinical resources.

Three major reasons were identified for making this happen:

- doctors manage massive amounts of resources through their clinical decision-making;
- doctors must learn to manage the major changes that are happening in medical practice – new technology, shifts from acute to chronic care, increased teamwork and increased patient activism;
- the institutions in which doctors work need to regard them as part of the organisation in order to get the best contribution from them.

Ideally, medical education should prepare most doctors to function effectively in the new environment of medical practice, but this is rare in

virtually every country. Rather, doctors must be motivated to seek appropriate levels of management development 'on the job'. The approaches to use will vary with each doctor.

Most doctors have no problems managing the care of their individual patients; it is when they are asked to consider the cost of this care in the context of the needs of the hospital to care for all its patients or the needs of the overall health care system, that the problems begin. It was suggested that there was an inverse relationship between the relative involvement of doctors in 'corporate clinical management' and classic patient care clinical management. Exploring this tension might give doctors a clearer understanding of what is involved in assuming a parallel level of management responsibility.

At each stage, doctors have to feel that their relative involvement in management is positive and 'makes things better', in order to keep them involved and willing to take progressive managerial responsibility.

Motivating clinicians

For doctors who wish to spend most of their time at the clinical level, feeding data back to individual doctors about their practice, and how it varies from that of others, can catch their interest and begin to motivate them to 'manage' their practice differently. Another motivating factor for practising clinicians is showing them that an understanding of IT, the working environment, and the roles of other health professionals can make them more efficient on behalf of their patients.

One participant described the 'magical thinking' of certain doctors about the time they spend with patients, and the fear that this will be compromised by any learning about or involvement in management. In reality, most doctors are spending more and more time negotiating for resources, tracking down results and filling out forms, and less and less time in direct patient care. Doctors also see other health professionals getting 'smarter' about how to negotiate the system, and they become increasingly frustrated at their own inability to make the system work for them, and even to understand managerial language.

In order to motivate these clinicians at least to understand the basics of management, they must be shown how it can improve their own time management, make them more effective at securing resources for their patients, and help them learn. As they learn how to cope with the changing environment and changing medical practice, their own self-

esteem can increase, their stress levels decrease, and perhaps, they really can spend more time with patients.

Programmes to introduce clinicians to management should use an analysis of their current activities as a building block. One should initially use teaching models that are familiar to clinicians, such as case studies and comparative clinical data tables. Respected clinical role models should be involved in the training and, in a sense, serve as 'product champions' for greater management awareness of all clinicians. If trainers or management consultants are used, they must be of high quality and able to understand the clinician's experience. If the doctors are demotivated at the beginning, further progress will be stopped. Finally, it is critical to build incentives, financial or otherwise, into the doctors' work routine to reward desired managerial behaviours.

Motivating clinical managers

The next challenge is developing methods to identify and attract those doctors who are potentially interested in a broader role in management and to prepare them to take responsibility at the departmental or organisational level. These doctors will have varying reasons for this interest. Some will be pursuing their own agenda – protecting their department, avoiding a 'stupid boss', seeking prestige or relatively greater perceived power in the organisation. Others will have more externally directed motivations – influencing the direction of the organisation's agenda as the patient's advocate, seeking a new career direction, learning a new language, or establishing better relationships with managers and colleagues. Starting at the point of each doctor's concern and giving them as much real responsibility with support as early as possible, were seen as critically important, since symbolic involvement would rapidly lead to disillusionment and withdrawal. The most obvious starting point is involvement in the question of the overall resource use of the organisation, and the tensions created between these demands and the traditional one-to-one doctor–patient concerns.

It is critical to have organised options for training and development in management for those individuals that are of a high quality, and responsive to their particular needs, strengths and weaknesses. Of all the countries represented, only Sweden described a formal preparation process for senior doctor-managers.

Most participants felt that there was still significant resistance, on the part of the doctors, to moving into management roles at the expense of their clinical work. There was considerable debate about a realistic balance of clinical and management time. All agreed that the reluctance felt by many clinicians is linked to two key issues:

- the attitudes of their peers who see increasing time in management as 'dropping out of medicine';
- the fact that few countries have clearly recognised career ladders for doctor-managers with the incentives and prestige that would make them as attractive as the rewards of a clinical career.

These problems will have to be addressed, if we are to move beyond the model of the 'talented amateur' or rotating doctor-manager, to one which provides for more experienced and continuous involvement.

The final question we asked ourselves was: what would happen if all doctors wanted management development training? Given the current level of resources for such management development, there would not be the capacity. Faculty development and different approaches to development work will be critical to expanding this capacity. There is also a need to prepare general managers to cope effectively with doctors and work with them as partners, rather than distancing themselves from the doctors or trying to isolate or defeat them.

The consistent message here was that the introduction of doctors to management should start with their daily problems and experiences. There are general management principles important to *all* doctors that, ideally, should be learned in their undergraduate education, but certainly must be built into their experience in the workplace and augmented by explicit development programmes. There is a smaller group of doctors who must be identified or identify themselves, and subsequently assisted to gain the higher-level management skills required to take on broader responsibilities at the department or unit level. We must also work to assure that rewards and reinforcement for these managers of clinical services are built into their career structure.

THE FUTURE

A part of our time together was used to focus on various scenarios for the future of health care delivery systems, and the implications for the role of doctors and doctors in management. Participants were randomly divided into four groups and each asked to envisage the year 2010 under one of four scenarios:

- free market
- equal opportunities
- global awareness
- hard times.

The constraints of each scenario obviously drove the outcomes in different directions, but as we reflected on the exercise, we were struck with a number of common themes.

First was the inexorability and, to most of us, unpredictability of change. We are clear that change will be a 'given' from now on, but the direction it will take and what the key influences will be, are less apparent. As professionals, many of us doctors ourselves, on the one hand, we found it hard to conceive of dramatic change in the system 'because of the rules'; on the other hand, it was clear that we are entering an era in which forces outside the health care system will exert enormous pressure for change. Shaping such change in the desired direction will be incredibly complex.

The medical and scientific model

Fundamental to the future role and credibility of the medical profession will be the position it takes in relation to patients. The profession has historically depended on the 'medical and scientific model' to be the basis for this relationship. In the medical model the diagnosis of disease is the critical event in a doctor–patient encounter, which will logically lead to the appropriate treatment. The relatively narrow emphasis on the diagnosis rather than the treatment has allowed the doctor to retain control of the encounter, to monopolise the expertise and knowledge. This more rational linear approach of the medical model supports a reductionist view, with specialists focusing on even smaller parts of the body and parts of particular organs. The needs of the whole person are

easily displaced by the fascination with a 'diseased organ' and the application of 'scientific' methods to address the narrow problem.

One alternative stance for the profession is the understanding that this form of clinical practice will become less relevant with the increasing dominance of chronic disease and complex bio-psychosocial illness models. It is also counterculture to the aspirations of creating hospitals and practices which can function as learning organisations. Fundamentally doctors of the future need to be 'reflective practitioners' who can both understand the nature of holistic clinical problem-solving and can contribute in varying degrees to the management and leadership of the health care delivery system. This will require a profound culture change in medical training and practice. This approach gave us some insights into the difficulty of the challenge.

Factors supporting change

- The role of physicians is changing and will continue to change. There are various possibilities relating to where the profession will be placed on differing continuums:

  autonomous – – – – – – controlled
  specialist – – – – – – – – generalist
  superstar – – – – – – – – worker

- Patients will be more interactive regarding their own health care needs and expectations, and the public in general will be more articulate and involved in shaping decisions about resource use. The key challenge is assuring that this involvement is based on maximum quality information relevant to the question at hand, and not only superficial 'consumer' concerns. Concern for individual and community health improvement will be critical considerations, and potentially ever more powerful influences on medical decision-making.
- Health professionals will be more interactive with each other under any scenario. Increasingly, roles currently played by physicians will be taken over by other health professionals, and new roles will be developed. The importance of inter-disciplinary understanding and collaboration was emphasised, but the difficulty of achieving it acknowledged.

- The State is still expected to play a critical role in the health sector under all scenarios, regardless of decisions about ownership and financing. In the more homogenous public systems, it is hoped that flexibility can be developed to allow for more local autonomy and responsibility for the implemetation process. For doctors in management, this would mean greater freedom from statutory roles and responsibilities thus allowing for more locally responsive work. In mixed public/private systems, clear policy frameworks will be needed to assure equity and quality, regardless of managerial structure.
- There are economic tensions in every scenario; even in those where resources are available, the decisions about alternative investments are inescapable. There will be a need for a framework for decision-making that involves key stakeholders. We hope that such a framework will ultimately ensure public responsiveness and involvement; the role the medical profession chooses to play in this process will be critical.
- There was an interesting identification of what we called the 'heretics' in most scenarios, i.e. those individuals who work at the margin to make change. We felt that most real change occurred here and therefore this area should be more of a focus for those of us involved in management and management development.
- Finally, there was a sense of both optimism and pessimism in each scenario, perhaps reflecting the trade-offs that will need to be made in a resource-constrained world of the future – there will be winners and losers, and the stakes may be very high. The ability to reconcile these inevitable tensions will be a critical managerial task at government level, and for general managers and doctors at all levels.

CONCLUSIONS

- Changes in the health care delivery system will fall heavily on doctors and are inescapable.
- All doctors need some basic managerial awareness in order to understand their working environment and maximise their own effectiveness within it.
- There needs to be a vanguard of doctors who are prepared to assume greater responsibility for the management of clinical resources beyond their individual practice.
- Organisations providing management development for doctors should base their programmes on a careful stakeholder analysis of their local situation, and assure that key stakeholders are involved in the development and delivery of programmes.
- Programmes for management development of doctors at every level must be linked to their existing activities, as a starting point, and must be continually modified to reflect their needs in the changing environment.
- Management development for doctors should begin during their undergraduate medical education and be available, as required, along the continuum of their training and practice. The methods used and faculty involved should be appropriate to the stage on this continuum and, increasingly (and where practicable), doctors' working environment should be their learning environment.
- Longer-term involvement of doctors in management of clinical resources will depend on the quality of development programmes and positive incentives, including a meaningful career ladder for those who wish to make a significant commitment to management.

APPENDIX

Proposed framework for papers from participating countries

All participating countries' teams were asked to prepare a paper addressing the following issues in their country.

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

The big issues

- The major reasons for introducing doctors to management and for involving them in clinical management.
- How long have efforts in this area been under way?
- The major barriers to success of such efforts.
- The major factors/forces for success of such efforts.

Career paths for doctors in clinical management

- What is the structure for career progression of doctors from the most junior position to senior clinical practice in primary care, acute hospital, or chronic care in your country, and what plans are there to change this? Are there specific roles in this career path for doctors who take on clinical management responsibilities, and what changes are planned?
- Are there labour contracts or legislative frameworks that affect doctors as managers – including specific functions, constraints and rewards facing doctors who assume roles in management of clinical services?
- What are the major obstacles to effectiveness of doctors in clinical management roles in primary care/hospital/chronic care settings?
- What are the major facilitating factors for doctors to succeed in clinical management roles in primary care/hospital/chronic care settings?

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

Using the continuum shown in Figure 1 to distinguish different stages of doctors' careers and different approaches to management development, please discuss:

The goals of management development for doctors

- What are the major goals of management development in clinical practice in your country? If they differ for different groups of doctors on the continuum, please indicate in what way.
- Please identify the major content areas that are critical to each level of doctor taught.
- How does management development for doctors relate to organisational development?
- Is the development addressing primarily individual or organisational needs?
- Is the management development primarily multi-disciplinary (involving doctors and managers, paramedics, etc.) or uni-disciplinary?

The process of management development

- What are the methods used for current management development work with doctors in clinical practice along the continuum outlined in Figure 1, ranging from one-off lectures to courses/degrees and on-the-job training?
- Who conducts the various types of training identified?
- What methods are used to evaluate the impact of management development for doctors? Who is involved in the process?
- Please provide a critical analysis of which techniques and 'teachers' work best in which settings for which group of doctors.

THE FUTURE

How should management development for doctors in clinical practice be shaped in the future to meet the needs of your country?

Figure 1 Continuum of management development activities for doctors

	Methods for sensitisation to management	*Varying management development programmes (courses through to degree programmes)*	*Training programmes specific to a particular role (e.g. clinical director)*
Undergraduate medical students			
Graduate training levels (e.g. residents/ house physicians/ senior registrars)			
Consultants/ specialists/ hospital physicians			
Physicians in non-hospital practice – GPs, others			
Medical directors			
Other			

MANAGEMENT DEVELOPMENT FOR DOCTORS

WORKING PAPERS FROM PARTICIPATING COUNTRIES

England & Wales

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

Doctors, like others in the clinical professions, see it as their prime role to deal with, or manage, the health needs of individual patients, whether in the hospital or primary/community care setting. However, individual patient management, while a crucial component, has to be seen in the context of an appreciation and integration of a whole set of interrelated activities, very firmly within the health service management responsibility of the doctor.

Clinicians might have the view that they have, informally at least, acted out the management role in the clinical world since the end of World War I (1918). Medical officers of health (public health physicians) had administrative control of local government hospitals until 1940 – perhaps, some would say, to the detriment of their impact on public health. In the 1920s and 1930s medical superintendents formed a group of clinicians who, together, were expected to take on the administrative role and function for the running of British hospitals. With the setting-up of the tripartite structure of the British National Health Service (NHS), medical officers of health lost administrative control of local authority hospitals.

The 1974 reorganisation of the NHS led to the formulation of District Management Teams (DMTs) consisting of the district public health physician (formerly the medical officer of health and renamed the community physician), district nursing officer, district administrator and district treasurer, as well as representatives of general practitioners (GPs or family physicians) and hospital specialist consultants. The major informal management role in the DMT was played by the public health physician – more formal, day-to-day power and involved responsibility being in the hands of the administrator. Generally, management was by consensus.

The 1983 NHS Management Enquiry Report – more commonly known as the Griffiths Report – recommended the introduction of general management at all levels of the NHS. The implementation of these recommendations, by 1985, emphasised that ultimate responsibility for day-to-day management of health authorities be given to individual general managers. Community physicians were neither perceived, nor perceived themselves, as the driving force behind the administrative/

management process. Hospital consultants played only a minor role in managing health services, mainly inputting at the staff committee level within their own hospitals.

Much debate ensued regarding the real power of doctors' decision-making, as well as, for example, the status of other clinical professions (particularly nurses) in the day-to-day running of individual wards and clinical specialisms. However, the reality was that a 'new breed' of manager had been introduced into the health service whose former expertise, interest and working environment had not necessarily been in health or other public service. General managers were recruited from industry, business, the armed forces, as well as from within the cadre of NHS administrators. In the main, the scheme did not particularly encourage doctors to take on general management roles and (not necessarily a related fact) the scheme was also noted for the number of, what were previously, non-health-service connected people who had not completed their general management contracts.

More recently, the Resource Management Initiative, followed by the current NHS reforms, has led to the emergence of clinical directorates and directors who have a clear managerial function, and who are mainly consultant physicians. General practitioners have been encouraged to become fundholders, and this has prompted them to take responsibility for enhancing the prospects of family health practices, and the performance of human/financial/physical resources. Public health physicians have developed their advisory and supporting roles towards the whole management process, applying their specialist skills to the implementation process – most notably their functioning as evaluators, assessors and monitors of local people's health needs through epidemiological surveillance. The integration of these (and other key) clinical specialisms, functioning at all levels of health care delivery, through appropriate commissioning, referral and provision, is as yet to be evaluated in terms of its effectiveness. It is clear, however, that such integration has to be at the very basis of a functional management infrastructure if real health gain is to be achieved.

Doctors in the UK, as in many other European countries, are thus becoming increasingly involved in management. Their clinical training and expertise might support effectiveness in their management role, through emphasis on analysis and problem-solving. The management of human, financial and physical resources, however, requires specific skills and expertise to cope with complex and continually fluid situations, and

with the constant interaction of often unpredictable social, environmental and organisational cultural forces and processes.

What is clear, so far, is that, in the UK, doctors have generally not been sensitised to management concepts or the principles of general management practice, either through formal teaching/training or through the more advanced action-based learning and problem-solving. Both of which, in combination, have ironically been predominant in cultivating their clinical abilities and their expertise in the management of individual patients' health care needs. More specifically, management development for doctors in clinical services needs to be conducted along a continuum of activities from merely sensitising doctors to management issues, to actively preparing them to play effective roles in clinical resource management for their practices or institutional directorates/departments.

There have been suggestions that management might be viewed, and utilised by clinicians, as a means by which loss of clinical freedom might be compensated through exercising power over human, physical and financial resources. However, management principles in practice need to focus both on the effectiveness of care the clinicians and those that they manage provide, and on encouraging clinicians to:

- achieve higher standards of care;
- influence management policies and decision-making;
- manage their organisations (directorates, departments or services);
- pursue and activate their own and their people's personal and management development.

Doctors need to be willing and be supported, in order to develop personal and management skills, expertise and attitudes which enable them to formally lead the organisation and the people for whom they are responsible. In particular, they need to:

- be accountable for the clinical service output of themselves and others in that organisation;
- ensure, through informed decision-making, the appropriate use of clinical resources for maximum efficiency and effectiveness for the health population they serve;
- develop, facilitate and sustain a team capable of producing outputs directly commensurate with preferred health care outcomes;

- determine those preferred outcomes through proper assessment of health needs of their given population;
- enable their organisation to maintain and sustain measurable high-quality health care to meet those needs.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

Formalised opportunities for management development and training have existed in England and Wales since the mid-1980s. In 1986, the NHS Training Authority (NHS TA) (renamed the NHS Training Directorate (NHS TD)) produced a discussion document entitled *Developing the Role of Doctors in the Management of the NHS*. This was widely circulated to all individual health authorities, the General Medical Council, the Royal College and the British Medical Association, as well as to all university medical schools and regional postgraduate deans, and to providers of management education and training for doctors. Intense interest and debate was generated, which generally revealed:

- a lack of clarity about the purpose and nature of management in the NHS as far as it related to clinical practice;
- considerable concern at the limited scope and patchy provision of suitable training for doctors who wished to develop their managerial skills;
- worries about the lack of guidance available at the local level on whether what was on offer was appropriate to the needs of clinicians;
- concern about who was ultimately responsible for training at the national level.

This led in 1987 to the production of a policy document out of the NHS TD, entitled *Doctors and Management Development*, which identified the need for education on management principles at different stages in a doctor's career, commencing with medical school. The document recommended that the undergraduate syllabus should include an introduction to the social, political, economic and other external forces which influence the development of the health service. It pointed

out that it was crucial that the next stage at which formal management education should occur, based on recommendations from the profession itself and from the regional health authorities (RHAs), was at the senior registrar level. For consultants already in post, who wished to develop their role in management, it favoured special development programmes, with emphasis on personal, individually tailored programmes and part-time, short-course/workshop-type training activities.

The document also made the point that public health physicians, with their basic medical training and their postgraduate education in epidemiology, statistics, managerial and social sciences, were uniquely qualified to support and even lead reviews of local issues, which forms a vital part of management development for clinicians in post. It was certainly true that since the 1970s the Faculty of Community Medicine of the Royal College of Physicians had offered a training syllabus well in advance of other clinical professions, which focused on the range of ingredients essential to the development of effective management practice. For the small minority of clinicians who wished to become full-time career managers, the policy document recognised that different and more comprehensive training methods would be required.

In 1989 and 1990 the NHS Management Executive (NHS ME) carried out an initiative, *Management Development for Hospital Consultants*, which motivated the formation of an NHS TD-led training programme entitled *Managing Health Services*. In its first year, 100 hospital consultants from across seven RHAs in England took part in mostly external business school courses. An evaluation by the University of Lancaster concluded that the consultants and their organisations had benefited, but that there should be more work-based learning, and that doctors other than hospital consultants should have the opportunity to be included in the programme.

A second-wave programme was initiated wherein doctors from all 14 RHAs took part. Educational approaches varied, from full four-week residential courses at external business schools, to modular in-house programmes run in conjunction with business schools. Towards the end of 1992, a mid-term evaluation report was produced by the University of Middlesex describing the remarkable degree of success which was being achieved in this second-wave programme, and highlighting the significant and measurable improvements in managerial performance which had occurred. Some of the findings presented in the report were by no means surprising, and perhaps merely confirmed what had already

been felt to be true, that is that consultants saw themselves as least competent in such areas as financial management, time management, performance reviews, handling disciplinary and grievance issues, and recommending improvements in the use of information technology. The report found that consultants rated their own performances more highly in areas with which they felt familiar, such as identifying room for improvements for service to patients, and chairing meetings. They also rated themselves quite highly concerning their confidence to become successful medical managers. Consultants participating in the programme were positive that they should have a managerial role. They were generally receptive to changes in the NHS and wished to influence the course of events.

In October 1992, a symposium hosted by the NHS ME and entitled 'Forward into Management: The Medical Perspective' invited doctors, senior health service managers, those responsible for training at the regional and district health authority, as well as members of university academic departments (including business schools) whose teaching/training and consultancy role particularly focused on health service management development and training. The symposium reviewed the progress of the two phases of the programme and among its conclusions was that:

- the support of chief executives and general managers was absolutely vital in developing the managerial role of doctors;
- managers required a culture which recognised and understood the management process if they were to work effectively;
- when selecting doctors for intensive management programmes, the needs of the local organisations should be carefully considered;
- managers should take full account of the fears of loss of clinical freedom, especially among consultants who are not clinical directors;
- the programme needs to become much broader and more flexible in its approach, developing management teams and using a variety of training methods.

Generally, there are very few organised schemes other than that discussed above. Hospital consultants in post who desire management training, can choose to attend modular training programmes or short courses/workshops offered by the health service management training

centres or opt for the 'Managing Health Services' programme discussed above, which is organised by the NHS TD. There are also a small number of organised schemes for senior registrars who can attend two-week training programmes organised by the postgraduate deans. Doctors in public health medicine continue to receive management training as part of their specialty training toward part 1 and part 2 membership of the Faculty of Public Health Medicine of the Royal College – sometimes in combination with part-time study for a university-approved Master's degree qualification. General practitioners acquire management skills through attending short courses/workshops which have gained PGEA approval, as do GP trainees whose vocational training scheme imparts some knowledge of management principles. A growing number of GP tutors, based at postgraduate medical centres, are offering personal and management development training initiatives in partnership with university-based health services management centres.

The NHS reforms referred to earlier underscored the need for quite radical structural and functional management development to happen quickly, and this was exemplified in the Resource Management Initiative, which particularly emphasised the formation of clinical directorates and the accompanying budgetary responsibilities for clinical managers. Clinical directors are generally finding that the knowledge, skills and time commitment required to run clinical directorates warrants intensive management training. The various approaches and efforts to prepare clinicians adequately for involvement in the management function will be discussed later in the paper.

The major barriers to success

The barriers to the success of management development and training efforts are numerous and were discussed in some depth at the October 1992 NHS ME symposium. The major issues raised included:

- some courses still tended to emphasise a mode of 'teaching management' or delivering management through information giving;
- operational strategic management issues were separated off as 'academic' subject entities. Management training for doctors was often seen as something separate from management training for

other health professionals (and indeed managers in other public and private sectors);

- there was no real evidence that the training environment was sensitive enough to the needs of participants and, particularly, their own managerial development in the context of the needs of their organisation;
- individual learning needs and styles tended not to be considered and the institution delivering management teaching decided what was to be taught;
- institution-based training courses tended to be preferred and were justified in terms of both time constraints and costs of doctors' time out of the organisation;
- doctors found it difficult to gain supportive funding for organised schemes, both formally linked to the Management Development for Hospital Consultants programme, and for other health service management development options within university of Master's degree courses and business school MBAs. Alternative ways of funding, and rethinking how resources could be more effectively utilised needed to be investigated as a matter of urgency in order to multiply the number of doctors going through management development and training schemes. Programme costs with only a limited amount of sponsorship prohibited people from considering the programme;
- management development and training had often been seen as essential only for people in senior positions. The other assumption linked to this was that junior people could not have delegated to them responsibility for the decision-making processes within the organisation. This is demotivating for energetic young people and could hinder organisational development;
- there was an assumption that management development and training were much more crucial for business planning and management for trust hospitals and GP fundholding, and therefore that management for doctors ought to be organised within the context of preparing doctors for that 'health environment';
- there was a lack of available business school places;
- informed choice, from the point of view of both the participants in selecting courses and of training institutions diagnosing and selecting people, was not an option open to anyone at present;

- there was some difficulty in participants seeing their management development and training in the context of real career development, since the culture and environment of the NHS, it was felt, did not encourage people to stay in their management posts for too long anyway. Health service mentoring and counterparting with training tutors in training institutions has not been satisfactorily established;
- it was difficult for participants to determine whether there had been any benefit to their organisation as a result of the training; and it was almost impossible to know whether money invested in training had been well spent to the benefit of the organisation, or the service in general;
- there was a distinct lack of variety of training alternatives for doctors to choose from;
- it was questionable whether the most appropriate consultants attended the training programmes;
- generally, there was no evidence at all that a critical mass of consultants with managerial training/sensitivity had been created for on-going service management sustainability through clinical activity.

The major factors for success

Feedback in the symposium and from evaluations from the Management Development Scheme for Hospital Consultants identified major factors which would enhance the effectiveness of organised training schemes:

- the creation of a learning environment for management development rather than teaching management was to be emphasised;
- management needed to be seen less as a set of separate 'academic' subjects, but rather more as developing the participating doctors' attitudes and abilities to function flexibly and meet the many demands of effective management;
- management training for doctors ought to be conducted within a wider framework of management training for other health professionals, and especially health management teams;
- individual learning requirements needed to be assessed, be at the basis of, and drive the content for, the learning experience;

- serious consideration had to be given for taking learning into the work environment, to reduce problems created by time and financial constraints for people attending courses. Emphasis should be put on the on-the-job training with teams/groups, within a new learning environment which was the organisation;
- in-organisation facilitation of management groups, incorporating doctors and even whole clinical directorates, would undoubtedly be a positive move away from the style of fairly didactic knowledge-imparting and skills development-type training which was predominant;
- educating doctors for the real world was the key, through developing an understanding of the ground rules of the game of management in health service, emphasising resource management and skills in the management of change, all firmly placed within the context of the business that doctor-managers were in;
- alternative ways to gain supportive funding and rethinking how sources (such as service counterpart tutors) could be more effectively used, needed thorough investigation;
- formal education and training needed to supplement practical/experiential education, rather than the other way round;
- transferring conceptual frameworks into practice had to be at the very basis of the education process for doctors who were keen to find ways of transferring ideological and philosophical ways of thinking into practical management;
- managerial team development for the sharing of power over the decision-making process needed to be incorporated into training, thus leading doctors through the process of understanding and practising situational leadership. This would encourage a shift away from doctors' reliance on the power of hierarchical managerialism and from the emphasis on their individual management development, towards the concept of the organisation as an entity of togetherness and an environment for learning.

New NHS reforms, in particular the *Patient's Charter*, offer opportunities for hospital and primary/community health care doctors to manage, that is, set priorities and make decisions in the context of constant change. We might, however, ask whether all, just some, or a particular group of doctors need management training. Both the definitions of management and the appropriateness of training for management need therefore to be seen in the context of:

- the individual doctor's position in the organisation;
- a series of skills needed by doctors;
- a special set of management values that need developing in relation to the organisation.

Doctors need to complement their clinical role in caring for individual patients or caring for population/local community requirements. The care that is required in order to meet those needs has both clinical and managerial responsibilities attached, since human, physical and financial resources have to be co-ordinated to satisfy health needs of individuals and communities. The future developments for doctors in management must consider:

- individual and community health needs;
- special responsibilities of doctor-managers;
- developing an ability for audit and evaluation of the impact of their actions;
- enhanced initiatives for management education and continuing education. Management education (encapsulating training and development) ought to be seen as an ongoing process for the development of professional management, and needs to focus on how doctors are using what they learn to effect the process of change.

There is disagreement as to the particular model to be used for change through management education. However, we favour a problem-based model, emphasising a multi-disciplinary approach to management education, as the most efficient and effective for doctors. Educational processes for doctors need to include practice and feedback through peer learning. Personal learning resources need to be created (for example, where open/distance-learning materials complemented on-the-job education) and experimentation needs to be encouraged to develop a willingness to learn from mistakes. A regular audit of education in practice is essential as a means for evaluating the effectiveness of training schemes in terms of impact on effective service delivery and on positive health gain.

In terms of priorities for management education, the crucial question is: which doctors need training? Clinical directors are certainly a priority group for which management expertise needs to be developed.

This prioritising would not ignore the fact that management education should be incorporated into undergraduate as well as postgraduate courses.

It is also becoming evident that doctors have no intrinsic right (neither has anyone) to adopt a leadership role, or self-designate authority over all decisions to do with health. A new move through management education would be to encourage delegation of responsibility for the decision-making process according to individual competence, commitment and motivation towards achieving qualitative effectiveness. Doctors are no different than any other health professional or manager in this respect.

The goals of management development for doctors

Any strategy for management development for clinical practice needs to have major goals based on certain key values and expectations which all doctor-managers need to recognise and adopt for the efficient and effective running of their particular organisations. These might include:

- management development must be seen as an essential component of all managerial activities. Every day managerial life ought to respect and nurture management learning opportunities;
- all management development activities must focus on helping the organisation to achieve its goals;
- management development must be clearly and practically relevant to the needs of teams/groups as well as individual clinical managers. Doctors need to be sensitised to the multi-disciplinary basis of team development. They should be aware of their own learning and self-development needs, as well as of those with whom they are working, all in the context of the organisation's needs;
- management development must apply to everyone involved in managing the NHS. The emerging needs of clinicians with managerial roles should be seen in the context of management development of other health service professionals with whom they will need to interact;
- there needs to be a joint responsibility between the organisation and the individual doctor for management development, working

towards a more progressive, innovative and flexible approach to 'getting things done' throughout the organisation;

- management development must aim to: enhance the satisfaction of doctors in their current jobs (managerial or otherwise); enable doctors to broaden their ability to manage and understand the functioning of the organisation; enable doctors to progress in both their clinical and managerial careers;
- primary emphasis for management development activity should be on practical application of learned management, through a process of on-the-job application of education, and where the working environment is the learning environment.

The major obstacles to the effectiveness of doctors in clinical management roles

For management development to be effective, it is important to try to eliminate those factors which are barriers to the establishment of a new and more appropriate role for doctors in clinical management. The institutional obstacles to be addressed are complex and multi-faceted:

- a continued emphasis on hierarchical structures and arrangements, where the institutional and organisational setting has established a culture which sees as alien the real and essential involvement and participation of doctors (with other health professionals) in the managerial decision-making process;
- a health service structure and system which militate against the institution/organisation/working environment being the major learning environment;
- a concern for the image of perfection, where the service has a low tolerance for clinical mistakes, encourages doctors to have all the answers and make the 'right decisions first time'. Attitudinally, this often raises unreal expectations of what management is about and distorts doctors' views of what management development ought to give them;
- 'medical exceptionalism', which assumes untouchable clinical competence and therefore a logical transfer of that attitude into managerial competence;
- the new culture of competition between trusts, which has encouraged an internal market, whereby doctors responsible for

clinical resources need now to concentrate increasingly on developing an instant and marketable, cost-effective clinical commodity, often in direct competition with their clinical specialist peers, both within the organisation and in rival institutions;
- a new, unclear and suspicious relationship between commissioners and providers of health care and health care services;
- work overload, creating constraints on time for other than reactive and 'crisis-type' management;
- lack of opportunities for appropriate training in basic management for personal effectiveness, and in operational and strategic management for the new NHS environment;
- lack of real incentives in an environment where rewards are inflexible, and immediacy of performance is an expectation.

Major factors to be in place for doctors to succeed in clinical management roles

A more conducive environment for doctors to manage clinical resources could be facilitated through such motivational factors as:

- the opportunity to work within the new 'business' environment created by the development of commissioning agencies and trust hospitals, as characteristically new organisations;
- the opportunity to develop exciting new roles, relationships and ways of working in the new NHS;
- opportunities to capitalise on, and pioneer in, what is an unclear and less predictable health service future;
- opportunities to develop professional, knowledge-based organisations, where an existing wealth of expertise can be shared and collectively nurtured, for an environment based on principles of inter-professionalisation in practice;
- a need for high levels of commitment from staff throughout the organisation;
- a desire for change and involvement among all staff, at all levels, in the spirit of a true participative culture;
- an emphasis on the working environment as the learning organisation, where on-the-job facilitation and strengthening of people's and groups' sustainable development and capacity to manage the organisation are a primary managerial role for doctors.

THE FUTURE

Management development strategy for doctors in the NHS

The strategy will be based on a framework of key components which, together, will have the potential to give ownership and provide the flexibility to suit needs and conditions at the 'local' level. The 'local' organisation is expected to be able to prepare and implement its own management development strategy, based on local doctors' management development needs, and to measure the performance of the organisation in ensuring that management development meets its local health objectives.

THE FRAMEWORK

1 Assessing the key elements of the organisation's development and management requirements, as derived from the organisation's goals and business/health plan.

The term 'organisation' refers here to the unit of clinical resource for which the doctor has managerial responsibility (logically, the clinical directorate/units, fundholding general practices, etc). The major aim at this stage would be to determine the level and type of management expertise needed for the organisation now and in the foreseeable future.

Action at the local organisational level would therefore entail:

- detailing the key elements of the organisation's future development;
- determining management roles for doctors;
- developing a specification for individual doctor–manager posts, using the competence framework developed by the NHS TD (1991);
- determining review arrangements.

At the national/regional level, these actions would be supported by:

- dissemination of the competence framework and the set of diagnostic tools by which organisations locally can review and assess their organisational and individual development needs;
- provision of training, facilitation and advice for supporting local organisations in these developments.

2 Identifying the competence and future potential of the organisation's management resource

We need to determine who our individual doctors with management responsibilities are, how good they are, and what future potential they have as individuals in becoming effective managers. We particularly therefore need to:

- identify the number, level, type, age and gender of all clinicians with management responsibilities;
- determine and assess individual clinicians' competence, and consider their future potential;
- determine the prior learning, preferred learning style(s) and career intentions of individual clinician-managers;
- retain and update certain basic data on senior clinical managers as a way of informing future executive recruitment;
- determine review arrangements.

At the national/regional level, these actions will need to be supported by:

- the identification of senior clinician-managers;
- the set-up and management of development centres, to provide a positive and confidential opportunity to identify and consider individual managers' development needs;
- the development of the appropriate database to inform future executive management recruitment.

3 Matching the management resource to the management requirements of the organisation

Once the organisation has diagnosed its management requirements necessary to meet its business/health plan and future developments, and assessed the capability and potential of its management resource, findings need to be matched and development plans formulated to bridge the gaps identified. This quite simply asks the organisation to state what its plans are to develop its clinical managers. At the local level this requires:

- formulating/updating a development plan for the organisation;
- ensuring and enabling all clinicians to have an individual management development plan, linked to an overall career plan.

At the national/regional level, support for local level action will need to be in the form of:

- preparing and updating a development plan to meet the aggregate needs of senior doctor-managers;
- ensuring all senior doctor-managers have an individual development plan.

4 Providing a wide range of development activities

While the diagnosis and planning stages are essential prerequisites, management development will fail unless appropriate development activities take place. Quite simply, what development activities are to be made available, as agreed, and which make maximum use of on-the-job opportunities for doctors?

Local action will include:

- developing a guide which indicates a range of development tools that can be used to tackle specific individual doctors' needs;
- encouraging a 'learning contracts' approach to all development activities, whereby agreement is reached between the individual doctor and the organisation on what learning and development outcomes will result from a particular activity;
- providing innovative and effective development activities as solutions to the organisation's, and clinical team/individual doctors' development needs.

At the national/regional level, these actions will need to be supported by:

- the production of a guide on development tools in relation to the competence framework referred to earlier;
- the provision of agreed development activities for senior doctor-managers detailed in, and arising out of, the development plan.

5 Focusing on outcomes

To ensure the appropriate diagnosis and delivery of management development, attention must be focused on identifying and stating desired outcomes.

Local action will concentrate on:

- stating the key outcomes to be achieved with the local management development strategy for the organisation;
- agreeing the outcomes to be achieved through development activities for individual doctors;
- identifying the outcomes achieved by both individual doctors and the organisation as a whole.

At the national/regional level, supportive action needs to take the form of:

- stating key outcomes of management development programmes for senior doctors;
- agreeing and subsequently identifying the outcomes achieved for individual senior doctors.

6 Implementing the strategy

The organisation needs to be able to assess the progress they are making in preparing and implementing their management development strategy. At this point, various monitoring mechanisms need to be adopted on a formal basis, including:

- developing internal monitoring arrangements in each organisation, especially through the identification of the key doctor-manager responsible;
- developing the local management development strategy;
- developing internal implementation/monitoring arrangements;
- incorporating management development targets in the individual performance review (IPR) objectives for senior doctor-managers.

These activities will need to be supported by national/regional action which:

- incorporates management development targets in accountability agreements for trusts' IPR;
- incorporates the need for 'provider' organisations to have a management development strategy in the contracting process;

- incorporates 'management development' in the annual review process undertaken by the NHS Directorate for Health Authorities and Family Service Authorities.

7 Evaluating the key aspects of the strategy

In order to determine which aspects of the management development strategy need improving, and in what way, and to be satisfied that the strategy is enhancing the organisation's effectiveness and the achievement of its goals, the clinical managers and their management teams need to:

- decide and implement an evaluation methodology;
- assess the extent to which the anticipated outcomes have been achieved and the contribution this has made to developing the organisation;
- provide feedback on the findings;
- motivate the process of continual improvement in the main components of the organisation's strategy, through refinement of findings from the evaluation process.

National/regional action to support local activities will involve:

- collating, aggregating and feeding back evaluations of management development activities nationally/regionally;
- providing advice on local evaluation as a result of lessons learned nationally/regionally;
- continually reporting back findings and developments to the NHS ME/NHS TD.

Management development for doctors in the clinical practice will, in the future, clearly be based on the benefits it brings to their local organisations and to their 'consumers'. The prime focus of management development activities (and therefore substantial investment of time, money and other human and physical resources) will have, as a priority, to account for the balance between the needs of the doctor, those of the organisation and those of the 'consumer'.

The strategy, and the action process described above, attempt to highlight that, as well as doctors, the organisation (and especially its

human resources) must be prepared for effective and efficient management. Therefore, groups and teams ought to be the main focus for management development, with doctors as influential parts of them.

We have identified a series of questions to be addressed at the conference which will enable us to take management for clinicians' initiatives into the future:

- What should be the prime focus of management development work for doctors in management?
- Where should the balance lie between the needs of the doctor, those of the organisation, and those of the consumer?
- What would be the key criteria for designing/developing a programme for doctors in management?
- Given limited resources, how should priorities for training be determined, at what level, in consideration of which (if any) career ladder and clinical specialties?
- In what way should the development of individual doctors be related to the development of teams?

There is some evidence that management training could be viewed by doctors as a means by which they hold on to their power base, in an uncertain environment, rather than see management as an effective and efficient means by which they can co-ordinate their organisations for the purposes of effective health care. Management development must offer new incentives for this attitudinal change.

Finally, ought we to consider the development of a multi-disciplinary MPH-type postgraduate qualification which emphasised practical problem-based learning, the organisation as the learning environment, and which genuinely combined clinical development with health service management development? This would be similar to, but a more sophisticated model than, the postgraduate training programme (though at present based in educational establishments) implemented by the Faculty of Public Health Medicine in collaboration with university departments and regional training leaders.

There is no doubt that there are still many issues to be thoroughly assessed and digested, and more questions to be properly answered, concerning the concepts and practice of management by clinicians. We hope this discussion paper will enable the conference and future EHMA initiatives, to better take this forward to practical and effective proposals

for the management of resources, enhancing the health and well-being of the communities we serve, and the capacities of the very committed people working in both the NHS and health services in Europe.

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Finland

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

The big issues

HEALTH CARE SYSTEM AND MEDICAL ORGANISATION STRUCTURE IN FINLAND

The Finnish health care system is financed mainly through national and local taxation. Local authorities (the municipalities) are responsible for both primary and secondary health care (hospitals). Health care is financed by municipalities with the help of a state subsidy, which varies between 30 and 70 per cent of the total costs. Primary health care is usually organised in local health centres covering the population of one municipality. Hospitals are run by regional federations of municipalities. As a consequence, the hospital or health centre board consists of elected politicians. A central planning system has been linked to the state subsidy, resulting in strict governmental control of the locally run health service system and its resources.

Major changes have taken place in Finnish health care since the beginning of the 1990s. These changes cover both financing and regulation of health care and can be summarised as follows:

- *State subsidy reform:* previously, the state subsidy was a fixed percentage of the actual running costs paid directly to the service providers. The lack of a cost ceiling was compensated by the strict planning system which allocated all new resources to service providers by the single item (for example, specialist posts). Since 1 January 1993, the state subsidy has been paid directly to the local authorities and is based on a weighted capitation formula. The municipalities add funds by local taxes, but the health care budget is in essence a fixed global one.
- *Decentralisation in public administration in general and in health care institutions in particular:* governmental regulation and planning have been extensively streamlined, giving more power to local authorities. The government health care plan has been transformed into a mere policy document. The same development is going on

within institutions. Unit and department managers are being given greater managerial freedom and decision-making power is delegated through a management-by-objective approach.

- *Purchaser-provider split*: The municipalities, which are now in charge of global health care budgets and responsible for the health of their population, will start acting as purchasers. Hospitals have lost their direct state subsidies and have increasingly to depend on income raised by providing services. Former restrictions on municipalities to direct their purchases only to the local public providers have been removed, thus leading to increasing competition among providers, including private ones.

All these changes are raising the interest among doctors towards management, and are increasing the involvement of doctors in the management of clinical services. In 1992, the number of physicians was about 15,000 (population per physician 350). About 40 per cent of them are working in hospitals and 20 per cent in health centres. All doctors in the public sector are employees of hospitals or health centres. This has created a medical hierarchy based on professional as well as administrative authority. The specialisation of medicine has led to hospitals being organised by clinical departments, each headed by a senior specialist. In Finland, traditionally, doctors have had a strong position in health care, and the medical director has been responsible for running the hospital.[1]

As tasks of hospitals grew more complex, the internal organisation developed. In the 1960s, two separate organisational lines were established: one for general administration, financing and resource utilisation, headed by the hospital director; and one for patient care and medical matters, being the responsibility of the medical director. The department head (chief physician) has the administrative as well as medical responsibility within the department, but during times of little financial constraint, no involvement in economic affairs is requested. Nurses are subordinate to the department head, but they also have a professional line organisation of their own. The director of nursing is a member of the hospital management team, which also includes the hospital director and the medical director.

Despite the parallel organisation, physicians have tended to dominate in terms of power.[2] The same type of organisation structure has been established in primary health care centres.

History of management development for doctors

Before the 1960s, Finnish doctors interested in public health or health care systems had to seek postgraduate education abroad, mainly the United States and the United Kingdom. Finnish doctors also received management training at the Nordic School of Public Health, which, though established in 1953, has only been open to doctors for regular management training since the 1960s. At the same time management training for doctors was started in Finland in the form of continuing education courses, mainly sponsored by the Finnish Medical Association. Since the 1970s, universities, professional organisations and the Finnish Hospital League have organised management training courses.[3] An administrative competency for medical specialists, requiring formal training, was established in 1979. Chairs in health care administration were established in 1977 and 1983.

Major barriers to involving doctors in clinical management

From the end of World War II to the middle of the 1980s, there was a constant growth in health care resources. Physicians were successful in acquiring new resources, especially expanding specialised services. Active management of resources was not required, in practice, until the economic crisis in the late 1980s. Accountability was restricted to professional matters only.

Health care as a public service takes place in a political environment. The rules of organisational behaviour have developed accordingly. The political nature of decision-making has somehow been exaggerated by the fragmentation of the system into local units each with a board of elected politicians. Hospitals and health centres have been organised as public administrations with strict internal hierarchies, and physicians have had administrative rather than managerial duties. Physicians have been used to seek influence and power by lobbying decision-makers and securing their power in formal regulations. This has led to an increasing pressure from politicians, administrators and other professional groups to limit the power of doctors.

MAJOR FACTORS FOR SUCCESS IN INVOLVING DOCTORS IN CLINICAL MANAGEMENT

Together, the changes in the health care system and the economic depression have made doctors more conscious of economic matters. Both the Finnish Medical Association and the Association of Junior Doctors in Finland have seen the importance of management development for doctors as a strategy to defend the position of physicians. The Finnish Medical Association established a permanent committee for management training for doctors as early as 1976. Over 95 per cent of doctors are members of the Association, thus giving it a strong power base.

For this paper we went through the journals of the Finnish Medical Association, the Association of Junior Doctors in Finland and the Finnish Society of Community Physicians published 1990–2. We found ten editorials or articles about management training of doctors. In most of these texts, both quantitative and qualitative improvement of management development for doctors was demanded. However, arguments for this claim were usually related to promoting the interests of doctors, rather than to concerns for the development of health care management *per se*.

Interest in management training among individual doctors has increased considerably during the last decade.[4] At the last annual meeting of the Finnish Medical Association, over 300 doctors took part in the sessions of management and administration for doctors. Also one-day courses on management arranged by the Association of Junior Doctors in Finland have been popular.[5,6]

Career paths for doctors in clinical management

MANAGEMENT AND CAREER PROGRESSION OF DOCTORS

Within the medical hierarchy described earlier, there is a three-tier system corresponding to the level of medical competence. Each of the 32 specialties has the same hierarchic structure. Junior doctors in specialist training work as residents (registrars); specialists (consultants) have permanent appointments; department heads (chief physicians) act as supervisors of consultants, and have both administrative and medical

authority. This structure exists also within primary care, where a specialty in general practice was introduced in the 1970s. In recent years the medical director posts have been changed to full-time appointments. There is no specific career path for physician-managers. Senior physicians with administrative duties are usually chosen on the basis of clinical or academic merits, not on the basis of management skills or management education.

In order to study the role orientation of physicians working in administration, a total of 39 chief physicians at hospitals and health centres were interviewed in 1987. Most of them said that they had not actively chosen a management career, but had been selected by colleagues to take up the administrative duties.[7]

Labour contracts for doctors as managers

So far, management education is not a formal requirement when appointing doctors to management or administrative posts. Specialists are appointed senior physician or department head by virtue of their clinical or academic merit. Management education or training, officially, give no extra formal merits. Only in small hospitals, where the medical director is a part-time post, an additional small payment is included in the salary.

Majors obstacles to the effectiveness of doctors in clinical management roles

- Administrative accountability is still required only in a formal sense. Delegation of authority is, in practice, unclear in many instances.
- Lack of managerial instruments linking clinical decision-making to control of resources. Physician-managers have a need for production control information on case-mix control, resource-based descriptions of clinical services and patient-related cost information. At the moment the management information systems are insufficient to meet these needs. However, patient administrative as well as clinical information systems are largely computerised, with high coverage and good quality, thus providing an infrastructure for management information systems development.

- Doctors are strongly profession-oriented. The changing contents of leadership require general manager qualities rather than specialist knowledge and interest in professional issues. The growing number of female physicians may influence this biased professional orientation towards a more balanced one.
- Lack of incentives and rewards for managerial duties.
- Lack of systematic management training and organisational development.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

The goals of management development

ACADEMIC EDUCATION

Undergraduate level

Some management education at undergraduate level exists in all five medical schools in Finland. Its volume and content vary from a few lectures to a separately run course on management. Management education is mostly given by departments of public health and general practice. Courses in forensic medicine also include some teaching in administration. At the University of Helsinki Department of Public Health, the course in management includes four major areas:

- the doctor's role and the professionalisation of medicine;
- the legal basis of medical practice;
- introduction to clinical decision-making and control of activities and costs;
- the structure of the Finnish health care system.

The course includes a few lectures, but consists mostly of training given as group exercises. The course also includes a seminar, which discusses presentations and written reports by the students on a

management-related topic. A formal examination ends the course. The volume of the course is 3 credit points (compared with, for example, the course in ophthalmology, which is 3.1 points). The course in management is one of three options in the public health programme and is selected by 25–30 per cent of students.

Graduate training

Graduate training for doctors leads to a specialist examination, which is administered by the medical schools. A mandatory 20-hour course in management is included in the curriculum. Among topics covered are:

- the Finnish health care system and its ongoing changes;
- the professional role of specialists;
- clinical decision-making and resource management;
- understanding public and political decision-making;
- quality assurance and continuous quality improvement;
- patient rights;
- human resource management.

These courses are arranged by medical schools. Owing to the great interest in managerial matters, several medical associations have arranged courses, which are also accepted by universities, to be included in the mandatory requirements. As a consequence, the supply of courses is unsystematic and of varying quality.

Specialists

Specialists may acquire an administrative competency qualification, which can be compared with a subspecialty licence. The training leading to the administrative competency qualification includes 220 hours of course-based training and a two-year internship. The course-based training covers:

- health care administration;
- public policy, administration and decision-making;
- leadership and human resource management;
- health economics and business management.

The internships are organised on an *ad hoc* basis. Service in a managerial position or in suitable organisational development projects is the usual way of gaining the required practical experience. Interest in the administrative competency qualification has increased considerably during the last few years, so much so that the medical schools have problems in responding to the growing demand. An additional problem is that no medical school has a course programme which totally covers the requirements. Students have to structure their own training by choosing from courses offered by various organisations. Initiatives to organise more comprehensive training schemes have lately been taken up.

Continuing education

One-off lectures on management, administrative issues, legislative reforms, etc., are arranged by a variety of organisations, including the following: the Finnish Medical Association, the Association of Junior Doctors in Finland, the Finnish Hospital League, the Association of Municipalities, university centres of continuing medical education, and commercial consultancy firms. The Finnish Association of Psychiatrists is presently organising its third continuing education programme in management for its members. This advanced course consists of five two-day seminars given over a period of eight months.

Content issues

Previously, management training for doctors was mainly concerned with legislation and administrative structures. Currently, the present health care reforms have reoriented much of the interest and training towards managerial issues in general, and funding arrangements, financial incentives and information systems in particular. Owing to several organisations offering courses, this reorientation has taken place rather flexibly and rapidly.

The changing environment, and especially new funding arrangements have initiated internal organisational restructuring in hospitals and health centres. During these reorganisational activities, substantial training of the personnel has also taken place.

Continuing education programmes, as well as in-house training, are typically multi-disciplinary, involving different professional groups and administrators. As many of these educational courses are used to

substitute specific programmes, for example the administrative competency qualification, doctors are increasingly exposed to multi-disciplinary training.

The process of management training

Most graduate and postgraduate training in management courses is a mixture of traditional lectures and team-work exercises. The continuing education courses usually work with cases involving a variety of specialists and practitioners. At present, comprehensive programmes using a personal development approach, based on problem-solving, project work and seminars, are missing. No systematic evaluation of the impact of management development has been carried out.

THE FUTURE

A new public health medicine specialist training covering a considerable number of management issues, is to be started in 1993. This five-year specialist training programme includes, among other topics, the following areas:

- health policy formulation, planning and implementation;
- expert support for purchasing agencies, including needs assessment, evaluation of health care interventions, and contract handling.

In 1991, a group of international experts was invited by the Finnish Government to assess the Finnish 'Health for All' policy. Among other things, the group drew attention to the 'amateurish' status of management within health care institutions. As a consequence, the Department of Health in its revised Health for All programme, gave high priority to management development initiatives in health care. In response, a proposal to establish a university-based one-year Master's programme in health care management has been presented by the University of Helsinki. The programme is conceived as a partly on campus, partly distance-learning course, and students would be required to work on a organisation development project from their own organisations. The funding decision concerning the programme is still pending. Plans also exist to revise the administrative competency

programme for specialists with the objective to tailor it according to the new leader roles in provider organisations.

In a recent memo presented to the Finnish Medical Association, the following scheme for a programme for management development activities among physicians was proposed:

- systematic development of managerial know-how through university-based courses, for example, the Master's programme;
- short courses on 'technical issues', for example, new legislation, funding arrangements, managerial tools, cost accounting;
- network for exchange of experience, for example, by organising regular seminars for physician-managers.

Future initiatives in managerial training will probably be tied to new programmes for involving clinicians in management. An illustrative comparison would be the Resource Management Initiative in the British National Health Service. A leading principle is to extend clinical accountability from a narrow professional responsibility to a combined managerial task of handling both clinical activities and resources. The key will be to describe clinical decision-making in terms of diagnostic, therapeutic, rehabilitation and support procedures. These parameters are part of the clinical process and express its professional content; but when sufficiently disaggregated, they are also direct measures of resource consumption. They provide the physician-manager with a tool to adjust the clinical protocol to the supply of resources; and, conversely, to express the resource needs for a clinical problem.

This combined approach to activity and resource control is the starting point for a health care management information system, useful to doctors and managers alike. It forms the basis for a product line organisation, cutting through functional barriers, and it is at the foundation of a process view of the health care system which has the patient as its main focus. That view can easily be extended to cover the whole range of services offered to the patient, involving not only different levels of care, but also the different professional groups and individuals taking part in the care process. By concentrating on the process and giving it a customer focus, both externally and internally, the foundation is laid for total quality management in health care.

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France

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

In France, medical practice operates in both private and public sectors. With respect to ambulatory care, practice is private. This liberal practice is payed on a fee-for-service basis and is mainly funded by health insurance which covers almost 100 per cent of the population and reimburses approximately 70 per cent of the cost of the fee. The fee schedule is negotiated between the medical trade union and the insurance system, and applies throughout the whole country. This negotiation is called 'Convention'. A few practitioners are not 'conventioned' and therefore apply a discretionary fee (with the reserve to be reasonable).

Even where practice is regulated by Convention, there is a private practice called 'Sector 2' which allows practitioners to apply a fee greater than that fixed by the Convention. In these cases, reimbursement covers only the Convention fee.

Practitioners are more and more tempted to enter Sector 2. This stresses the rift between the medical profession and the conventional system which has been applying a policy of cost limitation for many years. Indeed, from a medical point of view, the conventional fee does not increase sufficiently.

In hospital practice, both sectors coexist. In public hospitals, medical practitioners are appointed by the national or regional level of governmental agencies. Despite being wage earners, they are allowed to develop a limited private activity within their hospital. The management situation for physicians in the three main sectors of medical practice in France are highly variable. Private practitioners in ambulatory care rarely practise in a group. The French social security system provides few incentives for them to 'manage clinical resources'. In fact, the management skills required are limited to the basic economic and organisational aspects of their practice, with some external pressure from the financing authority to comply with average quantitative practice parameters. With little if any recognition of the need for optimising and co-ordinating clinical resources, and no structured framework for the relationship of their own practice with those of other providers, private ambulatory care physicians manage their practices like artisans. In the hospital sector, the New Hospital Law of July 1991 is still at the early stage, and the situation in hospitals can be summarised as follows.

- *In private hospitals*, two archetypes are found. The first group of physicians are also owners of the institution, totally or partially. In this case, they are totally involved in the management process, at least at the strategic and investment levels, some hiring managers for running the daily operations. With very light organisational structures, clinical management is empirically performed with explicit goals pertaining only to the economic performance, with little concern about quality and appropriateness. The second group of private hospital physicians comprises doctors under contract to institutions, usually owned by investors. In this case, physician involvement in clinical management usually takes place through discussions with the management team, with no specific function dedicated to this role.
- *In public hospitals*, management is performed through a dedicated body of public hospital administrators, who secure all major managerial functions. Physicians are recruited through ministry appointments, based on purely medical criteria. They are responsible for clinical units, but their involvement in the management process is highly variable. In the past, physicians in public hospitals were not totally in charge of management affairs, and very few medical director positions existed (if so, they were usually staffed with administrators). The new hospital law clearly offers a great deal of room for increasing the physician's role in the management and organisation of clinical resources.

It should also be acknowledged that some large institutions, such as the Assistance Publique de Paris, have developed various models of such training. However, none has become statutory nor recognised specifically in the career path of practitioners. Some pharmaceutical companies have also sponsored models of training seminars on the subject.

In France, three main areas are currently available as opportunities for developing clinical management. First, at the hospital level, the growing exposure of physicians in charge of assuming responsibility for the direction of services or departments, to managerial techniques, such as budgeting, developing human resources and establishing strategic options. Second, the revision of the general agreement between ambulatory care physicians and the social security. Third, the need for the development of methods of evaluation pertaining to diagnostic and

therapeutic strategies, their operation and their results, is a shared objective for all the physicians of the French health care system.

Another issue in management development for doctors is a new trend towards development of management training, as a complement to medical training, in order to cope with the demographic excess of physicians, which is currently at its top level. This new phenomenon must be taken into account, particularly in France, as management teams have never had any medical background. Some doctors choose this course, not only to escape from the bad demographic situation but also because they think it is worthwhile for hospitals to have medical skills in management. In addition, there is a significant effort to involve physicians in management at different levels.

The big issues

The major reasons for introducing doctors to management and for involving them in clinical management include the following:

1 Exponential increase in social expenditure (mostly medical).

2 Economic crisis since 1973.

3 Successive government cost-containment health policy.

4 Effort for cost containment made firstly in the public hospital sector (50 per cent of all medical expenditure):

- 1979: limitation of the percentage of budget increase in public hospital sector;
- 1983: shift from an *a posteriori* inflationary mode of funding (calculation of insurance grant as the fee per day multiplied by the number of hospitalisation days) to a constraining and *a priori* determined funding given on the basis of the previous annual grant and activity forecast (inconvenient because of the 'freezing' of the hospital situation);
- 1995–96: resource allocation on the basis of cost by DRG or pathology.

5 Shift from an administrative regulation-oriented hospital management to a true management inspired by the private sector.

6 Questioning of doctors' authority and effectiveness through ideology and publications, underlining the increasing iatrogenicity and the limited progress related to the development of technology and medical expense.

7 Due to reforms, new problems in hospital management: strategic choices in the context of scarce resources, and the necessity of multi-disciplinary skills to help decision-making (participative management).

8 Hospital Act 1991: new philosophy and methods in hospital management:

- new project-oriented tools: the department project; the medical project for the whole organisation; the institution project, a comprehensive project based upon the medical project;
- new duties for doctors involved at different levels in these projects (conception, carrying-out, etc.);
- need for medical care evaluation: quality assessment and cost/benefit ratio studies (this responsibility relies on the Medical Advisory Committee).

Major barriers to success

ETHICS

- Medical ethics: individual contract with each patient; medical act is performed for the patient's benefit, regardless of economic point of view (if opposite to patient's benefit).
- Patient–physician relationship based on confidence and trust. Physicians do not want to arbitrate if economic, societal and individual patient interests are conflicting.

Availability of resources

- Medical staff has stopped increasing in hospitals as technology becomes more developed, but hospital activity is still increasing.

Lack of skills and interest in management

- No direct benefit for medical practice is seen by physicians.
- Lack of managerial culture.

Fear

- Involvement of doctors in management is felt to be dictated by administration for economic purposes: creating financial duties ('stay within the budget') and giving no decision-making and managerial rights.
- Assessment procedures mainly medically-oriented rather than having a broader scope to include every component of management such as administration and financial management.
- Lack of incentives.
- No award or penalty currently exists, but recently a reappointment procedure for the head of department has been introduced.
- Lack of medical professional organisations really interested in medical practice organisation and functioning.

Major factors for success

1 In the context of scare resources and hospital system reorganisation, some physicians want to participate in the economic decisions, in order to:

   - help administration make the pertinent choice;
   - participate in hospital system reorganisation: many small hospitals are threatened by the reorganisation requested by governmental agencies and might disappear if not reoriented.

2 Recent reinforcement of administrative power in the hospital:

   - important improvements in the training of hospital managers;
   - higher and higher academic background of hospital managers;

- legal reinforcement of administrative power in the hospital by the Hospital Act 1991. Medical involvement in management is a way of counterbalancing this power.

3 Appropriation of evaluation concepts by medical and administrative parties (new generations, nurses, etc.).

4 New concepts in management:

- a considerable shift in management concepts (hospital management theories and Hospital Act spirit) leads to the sharing of power between the different hospital professions (doctors, managers, nurses, engineers, etc.);
- consequently, a shift occurs from an *a priori* control and centralised power to a both *a posteriori* and continuing assessment, and decentralised organisation (e.g. the Assistance Publique in Paris).

5 Beginning of accreditation activity:

- the private sector is creating a structure in charge of defining standards and of testing the accreditation system.

6 Recent creation of agencies in charge of developing medical assessment, both run by senior medical practitioners:

- National Medical Committee of Evaluation;
- Medical Assessment Development National Agency.

Career paths for doctors in clinical management

AMBULATORY CARE: GPS AND SPECIALTY PRACTITIONERS

1 After initial training, no career path in clinical management.

2 Development of management responsibilities or sensitising to evaluation and economics:

- health insurance profiles of prescription;
- non-compulsory continuing education offered by health insurance oriented to economic problems and evaluation methods.

HOSPITAL CARE

First step: hospital practitioner; *second step*: head of medical, surgical or biological department; *third step*: membership or presidency of the Medical Advisory Committee.

1 Appointments of practitioners and heads of department are made by co-optation and Health Ministry decision.
2 No appointment contracts or evaluative procedure for physicians.
3 Recent introduction of a reappointment procedure for the heads of department; criteria for evaluation not yet defined.
4 President and members of Medical Advisory Committee are elected by peers.
5 No medical director in public hospital.
6 Recent creation of a medical information system department run by a physician who does not belong to the management team but already has an important role in strategic planning.
7 No award for physicians with management responsibilities, for example, no financial bonus for the heads of department.

PRIVATE HOSPITAL SECTOR

1 Physicians are directors or wage earners or independent.
2 No career path in terms of management.
3 Recent creation of the Medical Advisory Committee.

Major obstacles to effectiveness of doctors in clinical management roles

1 Lack of training.
2 No positive or negative incentives.
3 Fear of administration to have to share the power.
4 No clear and recognised authority of doctor on the part of nursing colleagues (parallel nurse hierarchy).
5 No independent medical representation in the management team.

Major factors to be in place for doctors to succeed in clinical management roles

1 Training at every stage of management responsibility.
2 Positive or negative incentives.
3 Appointment contracts specifying management responsibilities and tasks.
4 Evaluation process for human resources.
5 Determination and commitment of hospital managers to develop involvement of doctors in management and their training towards this objective.
6 Reinforcement of medical power in clinical department staff.
7 Creation of medical organisations really interested in and in charge of medical practice organisation and functioning. Health insurance wants to create medical professional unions at the regional and national levels, different from current trade unions, scientific colleges and deontologic authority (Ordre des Médecins), to be their agents/advisers about medical practice and its organisation, management and evaluation.

THE GOALS OF MANAGEMENT DEVELOPMENT FOR DOCTORS

It is quite clear that management development for physicians should primarily focus on expanding the capacity of clinicians to provide a high quality of care for the patient. It should not be promoted to encourage an overlap between administrative responsibilities and clinical decisions, unless a clear organisational commitment is stated and implemented in the institution in order to encourage decentralisation. Management development in clinical practice could, next to its primary goal of improving clinical performance, enrich the professional role of physicians, improve their ability to co-operate with the various professions existing in modern health care, and provide access to a more diversified career path, so as to enlarge the vision of the place of medical practice in health care.

The various groups of physicians have different needs. Students and juniors should benefit from basic information and training in a systematic way, covering not only the main managerial dimension of the health care

system, but also general exposure to the fields of knowledge of management sciences from a broader perspective. Senior physicians gaining additional responsibilities in the course of their clinical practice, should get regular training in order to refresh their initial training and strengthen the areas in which they have a particular interest or weakness. Candidates for positions of head of service should attend a special training programme focusing on personal management, budgeting and negotiation. Appointed heads of service and board members should attend special seminars to answer their needs *vis-à-vis* such responsibilities.

The major content areas should include the main ingredients of the specialised curriculum designed for hospital managers, with specific training in evaluation. Programmes for younger physicians may include all the major areas: budgeting, financing, staffing, organisation, human resources management, group process development, communication, evaluation, logistics, and specific areas of management related to health care (clinical classifications, assessment methods, quality improvement and problem-solving tools).

For physicians playing the key role in the dynamics of health care services production (analysing, ordering, practising, co-ordinating, delegating and evaluating), it is quite clear that the various levels of training should share a very large body of training objectives and curriculum contents. Additional insights focusing on the characteristics of each step of career development should be offered, with prompt adaptation to the rapid changes in health care delivery, technological advances and managerial sciences. A strong emphasis should be placed on the flexibility required to adapt the level of training not only to needs, but also to the personal preferences of clinicians. In times where professional capability is the key resource for a high quality of care, the process of management development should be designed to help the motivated physician, and not as a compulsory burden for the clinician who may prefer to delegate some areas of responsibility to colleagues or other professionals.

Analysing the relationship of management development for physicians, it is quite clear that implicit and explicit connections with the organisation of the area of practice are prominent. This is more obviously true for complex organisations such as hospitals, but, in a co-ordinated care system with a growing place for home care, the importance of such ties pertains to all levels of medical practice. The link

with approaches in organisational development is one of the main perspectives in establishing the goals, contents, follow-up and evaluation of management development programmes for physicians. In our experience, it is also strongly connected with development of two levels of competence: information utilisation and decision-making processes.

In the French environment of the 1990s, it is hard to indicate whether the primary need for such programmes is of individual or organisational origin. We can only point out that, at the same time, there are both a very strong demand formulated by individuals, and a clear recognition of need for such an approach from the various institutional levels. The important factor is therefore this convergence of needs, which provides a unique opportunity for enriching the identity(ies) and culture(s) of the French health care system, and to facilitate the emergence of less individualistic professional behaviour in care delivery organisations.

The options for multi-disciplinary or uni-disciplinary approaches to training are open, because they should be related to training objectives, and not artificially decided by corporatism or utopian considerations. In other words, we prefer multi-disciplinary sessions when they really add coherence to the field of knowledge being considered. An example of this is the gathering of physicians with head nurses, administrators and inspectors for some programmes related to the implementation of new managerial tools. However, either approach cannot be planned, and it is important to consider the unique character of physicians: a body of highly skilled professionals, with considerable capacities for knowledge acquisition, in a situation of quasi-discovery for a major topic related to their career development. This portrait may legitimise the request for maintaining a significant level of uni-disciplinarity at least for some seminars, which are usually systematically enriched thanks to extra-sectorial contributions. It is important to remember that the vast majority of our doctors were trained with little use of group work, and that one of the relevant managerial goals is also to encourage better co-operation among physicians themselves. Team development can be easily stimulated through an on-site training programme using a multi-disciplinary approach.

THE PROCESS OF MANAGEMENT DEVELOPMENT FOR DOCTORS

As these training programmes are aimed at adult professionals, the following rules should apply in the selection of training methods. Priority should be given to participatory techniques such as cases studies, groupwork (for the reasons mentioned above), seminars/workshops and fieldwork. Lectures still play an important role but they should be used to strengthen understanding following previous readings, or as a synthesis in a given field of knowledge. Expert conferences can also be used, and there is a growing demand for involving professionals with experiences not necessarily pertaining directly to the health sector. In recent years, the development and use of computer-assisted learning has been introduced in some fields of training. Various media are also used such as PC spreadsheet programs and videotapes. Although the majority of existing training programmes are disconnected from the site of practice, we strongly favour an alternative approach, such as the ENSP 'Medical+'. This experimental programme – offered for physicians involved in expanded responsibilities in their institutions – mixes short sequences (four days) of intensive participatory training, with specific goals of practice and personal projects to be realised under the supervision of a 'companion'. The physicians return to their institutions in between sequences. Through this design, we intend to find an operational compromise on the difficulties linked to the education of doctors already in key positions. Training on site may interfere significantly with clinical activities, and experience shows that it is very difficult to mobilise physicians on the site of their practice. Before entering the programme, each participant is asked to define a project related to one area of development of the programme. The short sequences, delivered in a separate residential environment, and gathering together physicians from various institutions and geographic areas, encourage participation and communication and provide the opportunity to 'disconnect'.

When returning to their practice, between sequences, participants must accomplish two 'missions': one is to perform a critical analysis of their own system of information and decision-making, while the second is to work on the topic they have selected. Various topics are accepted such as: investment decision, organisation of a new service, quality improvement project, inter-institutional co-operation and incentive policy. During the programme, each participant has a designated tutor, in

charge of supporting the trainee in his project, with the capacity to access a short list of 'experts' specialised in the various fields of hospital management.

The matter of who actually conducts such programmes and who should conduct them in the future is very important. Currently, there is still considerable reluctance from the physicians themselves to have such managerial development programmes conducted under the auspices of hospital managers, which relates to the specific French situation, with a body of public hospital administrators not including physicians. The trend is to mix the various types of participant groupings, since the reservoir of physicians having both personal training/experience in management development and the skills for training and teaching, is very small in France. The teams involved usually gather (with selected competent physicians and administrators) professors from various backgrounds (sociology, organisation, biomedical engineering, economics, finance, etc.) and a sound understanding and experience of the field. Specific agreements are made with selected business schools. This list of people is still limited, and priority should be given to reinforce some programmes for the training of trainers.

In most instances, immediate and delayed evaluation of the programme is performed by the trainees, through various questionnaires and assessment tools. Apart from the analysis of the satisfaction of the user, it is too early to evaluate the impact of the specific approaches of management development for doctors. It is well known that young physicians with little clinical experience who receive full instruction in general management usually tend to take new positions such as in consulting or the pharmaceutical industry, thus preventing any measurement of the impact of their contribution to health care delivery.

At this stage of development, we rely on several committees in charge of piloting and evaluating the various projects connected with management development for physicians. The main one is the National Pedagogic Committee for Hospital Physician Training in Management, which was created in 1992, and which gathers delegates from the Ministry of Health, the various physicians' unions, the professional associations, the Conferences of Physician Presidents of Hospital Committees (both teaching and non-teaching), the private sector (both profit-making and non-profit-making), and the National School of Public Health. Among its objectives, this group has to pilot the various experiments and to evaluate their results. A working group has also been

created jointly by the National Hospital Directorate and the National School of Public Health. An internal development and research committee on physician education in management has worked since 1992 at the ENSP in Rennes.

Evaluation will also analyse the impact of on-site programmes, but the global process of change in the French system, and the multi-factorial character of the situation indicate that attempts to measure the outcome may not be realistic. We prefer to perform individual interviews, to organise a long-term follow-up and to establish relationships with the participants in the programmes, and to offer them new opportunities for further personal development through training programmes.

The evaluation of the various attempts to provide access for physicians to management development programmes is difficult, because the specific training packages are in the early beginning of their life. Much will be learned during the coming months, during which there will be an enlargement of the offer, and more diversified approaches will be implemented. The key concept is clearly a vast dedication to a change and modernisation process, in which the need for physician leadership must be acknowledged.

THE FUTURE

Today, several factors coexist in the French health system, which can strongly encourage the development of appropriate training programmes in management for clinicians. The main factor is clearly the ever-growing concern for health care costs in the country, highlighted by all political parties as being a priority. All governing bodies, financing authorities and unions acknowledge that the French system, despite some of its merits, is costly and requires better control and planning, as well as a deep change in terms of organisation and resources allocated. With difficult times ahead for western Europe, the need for a more efficient health care system is established. In addition to this economic pressure, French physicians are now more favourable to develop evaluation systems and seek performance improvements. This move certainly derives not only from ethical motivations or patriotism, but also from the clear consciousness that changes are inevitable, and that involvement and responsibility in the fields of management and evaluation are the best way to face the situation and to protect the future of medical practice.

Other factors can be considered as increased 'opportunities' for such professional development. One stems from the new regulation for hospitals: physicians have to improve co-operation inside the hospital, but also to take on more responsibilities. Moreover, the need for restructuring the hospital system through co-operation, mergers or syndicates requires more skills for the physicians, who will be involved at various levels of the process: strategy, operations, clinical management, communications, etc.

A final point to be noted regards the need of patients to gain access to clinical care with better management. Through various media campaigns, the medical profession has lost its image, and there is growing concern among the French public about quality, cost of care and professionalism among physicians.

In a system which is still characterised by a high level of autonomy for physicians, the main question mark is the design of incentives for promoting the participation of physicians and future physicians in management development programmes. The situation is clearly different for pre-doctoral students and for licensed physicians. Medical students can be motivated by administrative rules to get credits in such fields. Various optional attempts exist, with diverse content and levels, but management, evaluation, organisation are not at present officially included in the medical curriculum. However, during their final years of faculty, a growing number of medical students take additional training in management school or economic universities. Including such training in the early stages of professional life, and placing it at a level of importance, are certainly the best way to establish credibility, to obtain motivation and finally to graduate physicians properly trained in management, according to the needs of their professional life. Such changes will probably require one more generation before they occur.

The biggest challenge is certainly at the level of practising physicians. The scarcity of career perspectives has forced many practitioners towards management programmes as an option for new professional orientation. Practising physicians have today no clear incentive to engage themselves in this training process, except their own analysis of professional development. There are no requirements to follow any such programme at any level of the career. This is especially true for hospital practice, where no training or assessment procedure exists for such matters at the various steps of promotion: hospital practitioner, head of service, head of department. There is also currently

no statutory or financial recognition of such training. The same situation exists for the various positions to which hospital physicians can be appointed: medical board, committees, representation with external authorities.

It is highly recommended to respond to the growing professional demand for programmes designed to develop clinical management skills and managerial skills at large. Such responses could play a major role in the process of improving the French health care system, but also in providing physicians with new sources of motivation for their own involvement in medical practice and medical practice improvement. Better response to the existing demand (as documented by the ENSP survey in 1992) is a key issue for expanding specific programmes for physicians and for facilitating physician access to multi-disciplinary programmes or other training opportunities.

Several issues are still pending and deserve clear orientations for France. One concerns the recognition and support of the increase in competence, and the matter of incentives. The importance of self-determination also deserves attention. Another issue is the need for breaking organisational barriers (through multi-disciplinarity), and also the importance of enlarging knowledge and practice through trans-sectorial approaches. The 'intelligent' link with on-site professional life and responsibilities is crucial. The clear need for establishing a strategy of expansion of the number of qualified trainers is yet to be addressed.

From past experience and current practice, we feel that there is a large space in the health care community for communication and exchanges between countries, in order to gain understanding and knowledge from each other. This may lead to the consolidation and enrichment of each country's unique experience through the concept of a European programme of training in management for physicians, in a multicultural spirit. Such perspectives should not, however, make us forget that any major process of change is difficult, hampered by risks, failures and blockages, and that such difficulties are not only related to the primary target discussed here, but also to the capability of change of professional, political and social institutions.

The basic attributes of quality here are the same as those used for quality in health care: efficacy, effectiveness, efficiency, reliability, accessibility and continuity. This is one simple way to remind us, at each step of any approach which attempts to enlarge professional competence, that the whole process only makes sense if it is constantly and closely

related to the central point of our care models: the patient and the dedication of all professionals to the improvement of the quality of the services provided.

Germany

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS*

The big issues

Alhough Germany is currently facing the same challenges for health care management as other industrialised nations, almost no systematic efforts are being made to introduce medical professionals to the concepts of management or to involve them in the management of clinical services, other than by simply restricting resources. In order to highlight the major challenges confronting doctors in clinical management at present, and also to explain the lack of successful efforts in this area, some introductory remarks are needed.

MANAGING HEALTH CARE – A CHALLENGE NOT ACCEPTED BY THE MEDICAL PROFESSION

For more than a century, health care in Germany has been financed by a basically unchanged third-party payer system: by payroll taxes and subscriptions to statutory health insurance paying for both ambulatory medical care and hospital care. Health care was provided on the level of a – for those days – decent minimum for everybody. A small profitable sector of direct billing did exist alongside the statutory health insurance for patients with appropriate private means. Until 1933, a well-developed and extensive system of public health care, tax-financed and organised by the public administration, represented one of three clearly separated institutional mainstays of a non-comprehensive health care system – with physicians in private practice and hospitals. In the first half of the century, the limitations of the diagnostic and curative procedures and

* This paper is based on the experience of piloting a multi-disciplinary postgraduate training module for health care management at the Medical School, Hanover, as the first one of its kind at a medical faculty in Germany. It is also based on the discussions which took place at a national workshop held in Witten, on 4–5 March 1993, on the future educational requirements for public health, in view of a reform of undergraduate medical education in Germany. Last but not least, a number of colleagues with experience in the 'pathless' field of health care management in Germany have contributed their views.

technologies then available in medical care, together with the professional monopoly of medicine, and an acceptance of limited resources during a period of extremely difficult economic and political circumstances, set problems of health care management aside and left them in the hands of bureaucracy. Strictly determined by legal regulations, the system never developed distinct elements of a market or a multipayer structure, and the already little scope for free contracting was almost removed.

Today, the system has developed towards heterogeneous and distinct subsystems, with conflicting regulations in terms of law, organisation and function. In particular, ambulatory medical care and hospital care form two strictly separated legal and institutional sectors, though both are financed by the same statutory insurances. From the beginning, aspects of social politics determined the system and gave, by tradition, autonomy to many professional associations, self-governing bodies, etc. The relevant regulations show features of monopolies: direct influence by consumers or government is almost impossible. Altogether, the health care system and its over-restricted statutory public contract system, including insurances and physicians' associations, can be seen as a 'museum of the time of Kaiser Wilhelm'. There is widespread agreement that the system is far from being functional in the sense of a comprehensive health care. Steering instruments using economic incentives are weak, especially in the hospital sector. The expenditure for which ambulatory care physicians bear responsibility, when acting as purchasers of health goods and health services by prescription and referral, is restricted by bureaucratic controls. Many examples show how resource allocation according to the needs of the population failed. Intrinsic inefficiencies are the main challenge in the German health care system, though a dramatic account of the economic situation is not justified. We find:

- basic management inefficiencies which lead to imbalanced effects in different sectors of health care;
- bureaucratic waste of energy, where attempts are made to improve management;
- lack of efforts to improve management, where necessary and possible.

Clouding issues

The alarming readiness of the medical profession to serve political purposes beyond the needs of the individual seeking care, under the Nazi dictatorship, inhibited almost any discussion about health policy among doctors after the war. The idea that any kind of policy – even a macro-economic one – should be seen as more important than the needs of individual patients or particular health care institutions was rejected. Medical professional standards set the only measure. The development of medical care was oriented towards individual needs as perceived by medical staff, clinical procedures and specialisation, and was never questioned. Public health services were reduced constantly. Epidemiology and all kinds of public health research played an extremely marginal role at medical faculties. Health policy and health economy were discussed with reservation, and were in no way integrated into medical professional culture.

The economic growth in the western part of Germany generated annual increases in health insurance expenditure, starting from a level of just above 15 per cent in the 1950s and 10 per cent in the 1960s, and increasing to some 20 per cent from 1971 to 1975. These increases had been brought about by the introduction of expensive technologies and were legislatively mandated by expanding insurance-covered services. Since there was no revenue scarcity until the 1970s, medical care and resource allocation were not subject to any of the broad public discussions which occurred during the creation and reorganisation of the British National Health Service.

On the institutional level of micro-allocation, a similar situation occured. The leading medical staff of hospitals did not feel, and were not held, responsible for the economic performance of their own institution. No qualification besides medical skills was decisive for their careers. Utility and quality aspects were discussed only from a medical point of view – sickness funds had almost no possibility to remove 'bad apples'. In the ambulatory sector, a relatively small number of physicians, high fees and low costs did guarantee high incomes even without paying any attention to managerial issues.

Barriers to management development of doctors

In the 1970s, the German economy was in the middle of a recession; the soaring health expenditure became a major public and political concern,

and for the first time the Federal Government intervened forcefully into the decentralised national health insurance system. In 1977, the first in a series of federal cost-containment laws was enacted. Annual increases in health insurance expenditure had been limited to the growing rate of incomes. This link between economic data and expenditure for health did not correspond at all to the demand for medical care. In view of its deficit steering potential, cost containment had resulted in strict price containment. The administrative approach of health insurance was aimed merely to limit expenditure with no regard to need or utility of services.

The real income of ambulatory care physicians decreased in the 1980s. The supply side reacted by increasing the number of services per patient, which resulted in price decreases for many services. With a rapidly growing number of physicians in practice, handling fixed total revenues became difficult for the self-government of physicians, who receive 80 per cent of their revenue from statutory health insurance funds. The regional association used to negotiate, within limits set by legislation, the overall pay for physicians' services (now capped) with the regional statutory health insurance funds. The relative value of particular procedures and some administrative regulations was fixed on a federal level. As a result of competition between physicians of different specialties to maintain individual income, the self-government of physicians was blocked and was immune to political action. Several small-scale attempts to establish innovative structures did not find any support. On the side of the medical profession, no consensus on politically relevant proposals for reorganisation of ambulatory health care could be reached between well-guarded professional interest groups. The development of a professional profile for doctors as health care managers was limited to that of the predominantly honorary role of officials in the self-governing boards. The lack of managerial competence on this level is to be blamed for the weak position of the medical profession in the current public debate on health care reforms.

At the same time, physicians in hospitals outnumbered by far their colleagues working in other settings. Hospital physicians are not formally involved in management, with the exception of medical directors. Hospitals are managed by their administrative departments, which are led by general managers, usually economists. Reimbursement of hospital care used to be on a per-day basis, irrespective of intensity of care or length of stay. The per-day rate was fixed prospectively between hospitals

and health insurance funds to cover the current or operating costs of the hospital, including salaries for hospital physicians. Cost-shifting from the ambulatory sector and poor co-operation between health care structures support centralisation and the dominant role of hospitals. The finance system and the inadequate use of hospital capacities through deficits in home care and professional and political interests do not allow to plan against over-hospitalisation and inherent inefficiencies. Unlike the ambulatory sector, cost-containment measures in hospitals have had almost no effect.

Factors for success

Management development for doctors will be encouraged by a change in the health care system. The direction of the ongoing change in Germany has more appeal for a market orientation. In favour is a dual system with a basic element for protection against severe acute diseases. This can be carried out by the existing system with income-related payroll taxes and benefits for everybody, irrespective of socio-economic status. As a supplementary element, there will be additional insurance plans available, financed by risk-oriented premiums, and supplied according to demand.

The public sector will be budgeted. Rationing of health goods will be necessary on the level of macro-allocation. Expertise and management skills of doctors will be essential in order to create and conduct acceptable procedures (for example, managing waiting-lists). Cost/utility analyses will be necessary to define those services and technologies considered as the decent minimum benefits. On the micro-allocation level, particular allocation decisions and the rationalisation of medical care will need assistance from competent physician-managers in the hospital as well as in the ambulatory sectors.

The private sector of supplementary insurance plans will have the features of a health market. The provider–purchaser split may become apparent. Provider organisations will possibly act for their (physician) members, negotiating and contracting various kinds of health plans with purchasers according to demand. The evaluation of performance (quality assurance, risk assessment, technology assessment) will be a major field for management by doctors.

Career paths for doctors in clinical management

Young doctors are almost entirely clinically trained, even for primary or chronic care. Their work is exclusively oriented towards the individual patient. Defined roles in clinical management exist only for medical directors who have a say in the diagnostic or curative procedures provided by the hospital, and can allocate the necessary equipment and human resources. After clinical training, ambulatory care physicians must spend six months in practice to become familiar with the regulations of the statutory health insurance. To achieve management skills for their own private practice remains a problem to be solved by individual doctors on their own. Doctors who take on management responsibilities in the administration of health insurances, pension funds or the public service find themselves outside their professional community and have to rely on the various but restricted in-house training programmes run by their institutions. In some regions, courses for leading hospital physicians are organised by the German Medical Association , or by the Association of Statutory Health Insurance Physicians for self-government officials. Postgraduate public health programmes (MPH) have been recently introduced at several medical faculties, and offer specialisation in health care management.

It has to be explained to the medical professional community that clinical management is a source of support for clinical work and that it does not endanger the professional role and values of physicians. It has to be made clear that clinical work needs support and improvement by appropriate managerial skills and measures, without necessarily implying a dominance of economic or bureaucratic views of the professionals involved. The necessity to manage limited clinical resources, to meet needs and demands, and to maintain quality so as to survive competition will focus on the following aspects of management:

- the functions of managers in health care;
- economic skills (budgeting and resource allocation, managing and implementing change, quality assurance and risk management);
- the nature of the organisation in a health care setting;
- human resources;
- managerial skills (motivating staff, leadership skills, managing groups, staff development);
- ethics in health care;
- politics.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

The goals of management development in clinical practice

For undergraduate students, critical reflection and understanding of different professional roles, communication skills, insight into the implications of organisations and institutional structures, the principles of resource allocation, and knowledge of ethical issues in medicine, are required for the understanding of management in health care. At undergraduate level, medical students should also become aware of the context and conditions of physicians' work in a problem-oriented, self-directed learning process. Some field experience is the necessary starting point.

At graduate training level, clinical decision-making with all its aspects should be emphasised as well as key techniques of management, such as communication and co-operation, information systems, and stress and time management. These aspects should be more intensively discussed in critical reflection on daily practice. Qualified and successful co-operation within ongoing management processes should be encouraged, rewarded and supported by occasional management development programmes for hospital physicians (for example, problem-oriented workshops or courses of limited length). The skills and expertise of the participants should be used to handle current management problems.

Both hospital physicians and physicians in non-hospital practice should work on special skills, such as human resource management, quality assurance, risk management and resource allocation. Clinical managers should cover the whole range of management skills to be able to guide, supervise and integrate particular individuals and particular qualifications towards effective management. Physicians in non-hospital practice should be included in a way suitable to their ambulatory care setting. Training programmes for clinical directors, or other kinds of definite clinical managers, should be connected with the appropriate professional position and responsibilities.

The concept of productivity in the production or provision of health services leads the attention to the special, often unmeasurable, character of input and outcome. To maintain a common idea of effective work, meeting the needs of patients, and to adjust a clinical unit to rapidly changing methods and utilisation patterns, a continuous organisational development is required. For this reason, management development for doctors has to address primarily organisational needs. This implies the inevitably multi-disciplinary character of management development in health care, which can in turn compensate for one-sided professional views.

The process of management development

The present situation does not allow any coherent description of management development for doctors in Germany. Lectures, training programmes and courses are offered by some private agencies and professional associations. Management schools and consulting firms offer a variety of management development schemes. A variety of educational scenarios with a participative approach has occasionally produced acceptable results. Combinations of lectures, exercises, case studies, distance-learning packages, day-books and inventories, are all appropriate especially for on-the-job training.

At present an evaluation of the impact of management development for doctors is not possible. Politicians and institutions complain about the lack of medical expertise they would need for their decision-making. Substantial management and planning processes are carried out without any medical expertise being systematically involved. Administrative and legislative conditions, and the lack of a professional profile for doctors as managers in health care, do not attract physicians and give them little opportunity to join professional and coherent management processes.

Effective professional learning, particularly in the field of management, should be defined as the achievement of change in practice, and this process demands the integration of the relevant body of theoretical knowledge and the acquisition of certain skills. Bearing this in mind, management trainers and lecturers must reconsider their own skills, and be prepared to learn and apply adequate educational approaches and methods. This means that training courses for lecturers should be provided prior to the implementation of management courses.

THE FUTURE

It is likely that a more competitive and market-oriented health care system will support the introduction of doctors to concepts of management in Germany. It can be assumed that health care management will be institutionalised on a broader scale and at different levels. This may be of advantage to the medical profession mainly in three fields:

The ambulatory care sector

Physicians in non-hospital practice have to deal with rapidly increasing managerial problems without the skills, resources and tools for effective management. A trend towards professionalisation may bring out new management structures in ambulatory care to assist them.

The hospital

Some examples of effective management in nursing and organisational development in hospitals have shown that the creative management of these complex institutions can open new perspectives for the productivity, efficiency and quality of services provided. Physicians may play an important role as clinical resource managers, and develop a new professional profile while doing so.

Health policy

Ethical considerations will be publicly discussed when new and expensive clinical techniques are at hand, but rationing of health goods is inevitable. Problems of medical ethics and allocation of resources in health care cannot be solved without the co-operation and support of the medical profession. The necessity to do more with no more resources will require evaluation and assessment of medical programmes, procedures and technologies. Needs assessment and epidemiological data will be of major impact on political decisions. Physicians may assist management procedures as experts and specialists.

Ireland

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

The Irish public health service provides primary, secondary and tertiary care for a population of about 3.5 million. The service is organised through eight regional health boards, and is expected to cost about £1.7bn in 1993, corresponding to 6.8 per cent of GNP. Funding comes from general taxation. Services are managed and delivered on a programme basis. There are three programmes: Community Care, Special Hospitals (mental disabilities and mental illness) and Acute Hospitals. The public health service provides comprehensive health and social care for the poorest one-third of the population; the remainder pay for some of the services, notably for general practitioner services.

Almost 5,000 doctors work in the public health system; these comprise: some 1,000 consultants, 2,100 non-consultant hospital doctors (660 of whom as registrars), 200 community care doctors and 1,570 general practitioners.

There is a mixture of public and private health care provision in Ireland. Consultants' contracts with the public system permit additional private work, once consultants' commitments to the public system have been honoured. General practitioners are independent contractors to the system, and are paid on a capitation basis for the public patients in their care. They are also entitled to attend private patients. With a few exceptions (e.g. chief psychiatrists, and the 'master' system in the big maternity hospitals), doctors in Ireland have not yet been heavily involved in the management process. Some are members of medical boards, hospital management boards and – with the hospital administrator and the director of nursing – hospital advisory committees. These roles are representative, rather than executive, in nature.

The big issues

The major reasons for introducing doctors to management and involving them in clinical management can be summed up under four main headings:

- economic and political factors;
- new thinking about management;

- new emphasis on quality;
- contract of employment for consultants.

The first three are probably common to most other European health systems; the fourth is uniquely Irish.

Economic and political factors

In common with other OECD countries, the Irish health service budget expanded significantly in the late 1970s and early 1980s. This period of expansion was reversed with swinging cutbacks in the late 1980s: we were the only OECD country to suffer real reductions in the public health budget. It is now recognised that the health service will be lucky to keep its budget in line with inflation. These circumstances have led to a drive for efficiencies in the system. Since doctors' decisions determine in large measure how resources are allocated, their active involvement in resource management is seen as critical to cost containment and efficiency. Health is also a sensitive political issue. The demand for health care always outstrips supply, and rationing is taking place, albeit implicitly. Doctors are intimately involved in the rationing process, since their decisions about whom to treat, and how, have implications for other patients.

New thinking about management

When health budgets were expanding in the 1970s and early 1980s, sufficient resources were available for service expansion and development. There was a perception at the time that the job of management was to negotiate the largest possible budget allocation. It was then the job of those delivering the service to decide how to spend it. Now, however, the budgetary process is much more stringent, and resources will continue to be limited. For example, hospital budgets in the future are likely to be based on projected case mix, cost in accordance with a DRG system that is calculated on a 'best practice' basis. Negotiating the use of what limited resources are available will be a complex task, which is best approached on a multi-disciplinary basis.

New emphasis on quality

Increasing consumer expectation, and the apparently wide variations in medical practice and outcome, are putting pressure on doctors to justify the quality and outcomes of their work. Doctors are best placed to evaluate clinical quality and outcome. A clinical management approach provides the opportunity for doctors to exert peer pressure on their colleagues to conform to agreed standards of professional practice.

New contracts of employment for consultants

New contracts of employment which set out an expanded managerial role for consultants in the public health system, were introduced late in 1991. Doctors are now to become involved in management:

- at individual level, through the drawing-up and negotiation of individual annual practice plans, and participation in medical audit;
- at unit/department level, through the development of clinical management;
- at hospital/institution level, through the appointment of clinical co-ordinators, to help align individual practice plans with the institution's corporate plan.

Employers are obliged to provide the resources and facilities specified in the agreed practice plan. They are also obliged to supply appropriate information for doctors, and the necessary support and organisational system for medical audit.

The process of bedding down the details of the contract are under way. No clinical co-ordinators have been appointed yet. Three hospital sites have been chosen to pilot appropriate forms of clinical management. One of these hospitals has chosen to adopt a clinical directorate approach, and is working through the organisational changes needed to implement the new system.

Major barriers to success

The major barriers can be grouped under the following headings:

- Attitudinal
- Financial
- Organisational
- Environmental.

ATTITUDINAL BARRIERS

Doctors are not convinced that being involved more directly in management will address their primary concerns. They value their clinical independence and are concerned that their role of advocate for the patient will be eroded without any suitable alternative being put in its place. There is also a lack of trust and a fear of a 'hidden agenda' to be given responsibility without power, i.e. of being 'dumped on'. Most doctors have no experience of management at a practical or academic level, and are unsure of the role they would be expected to play. There is a concern that taking on a managerial role, e.g. clinical co-ordinator, might affect one's professional prospects afterwards.

FINANCIAL BARRIERS

Doctors are concerned that, if they become clinical managers, the commitment will eat into the time normally available for private practice, and have an adverse effect on them financially. Some are also conscious of the opportunity cost to their public patients with scarce resources, i.e. a doctor not being as involved as possible in the job he/she is best trained to do.

ORGANISATIONAL BARRIERS

At present, there are no structures for clinical management except in one pilot site hospital. Some doctors are concerned that the notion of clinical management, being counter-cultural within the organisation, would receive no support. Until recently, there has been no significant pressure, from doctors or managers, for doctors to get involved in clinical management.

Success factors for involving doctors in management

The major success factors can be classified as:

- Attitudinal
- Experiential
- Organisational
- Environmental.

Attitudinal factors

A significant proportion of health workers, doctors among them, believe that things are changing and they want to be involved in leading that change. There are others who believe that they have accomplished all that is possible at a professional level, and can now make their contribution most effectively through a managerial role. For a small minority of doctors, the commitment to public health is such that they will be involved in management, if that is what is required to achieve their ideal.

Experiential factors

Quite a few of the younger doctors in Ireland have trained and worked abroad. They are used to other systems and structures, and have seen how the service can be improved if doctors involve themselves in clinical management.

Organisational factors

The new contract for consultants has given notice that new forms of management and new structures for involving doctors in management will be adopted. New structures are being tested in the pilot organisations chosen, and more widespread application will follow. Clinicians' involvement in management in now being seen as relevant to the organisation's future.

Environmental factors

Within the wider health environmental, the Department of Health is supporting the initiatives on clinical management and medical audit, and is financing some of the pilot work in these areas, as well as some management development initiatives. Regional health agencies and independent voluntary hospitals are also supporting it.

Career paths for doctors in clinical management

Primary care

General practice

Much of the primary care in the public health service is provided by some 1,570 general practitioners, who work as independent contractors to the system. The number of these doctors is limited, and entry is mainly by open competition. For 1994, doctors competing for these jobs will need membership of the Irish College of General Practitioners, through a structured vocational training programme following graduation.

Community care doctors

The professional career path for community care doctors begins with area medical officer, then senior area medical officer, leading on to director of community care (DCC). The DCC job has a large managerial component, involving leadership of a multi-disciplinary team. Generally speaking, this structure has not worked well. Plans are afoot to change it by abolishing the role of the DCC and by appointing directors of public health. The entry requirement for these jobs will be Fellowship of the Faculty of Public Health Medicine.

Acute care

Doctors in the acute hospital system follow the well-trodden path of senior house officer – registrar – senior registrar – consultant. It is very common for Irish doctors to work abroad at postgraduate level, returning to sit the required Fellowship examinations. The structure of medical

posts within hospitals is quite pyramidal. As mentioned already, the new consultants' contract provides for doctors' involvement in clinical management at individual, departmental and hospital levels.

Psychiatric care

Mental health services, and services for people with physical and mental disabilities are consultant-led and fall within the Special Hospitals programme. The professional career path for doctors in this area would be the familiar one for consultants generally (i.e. senior house officer – registrar – senior registrar – consultant), plus membership of the appropriate professional college.

Major barriers to doctors' involvement in management

The major barriers to the successful involvement of doctors in clinical management have already been mentioned. Most of them stem from uncertainty, resulting in:

- reluctance to become involved in, or supportive of, a clinical management system;
- fear that the advocacy role will be neglected;
- concern that too much time will be spent on the management function, to the detriment of patient care;
- perception that doctors may not be welcome in the managerial fold because managers will also feel threatened.

There are also financial barriers involving possible loss of earnings for the doctors who become clinical managers, and also the opportunity cost of assigning a highly trained doctor to a managerial role.

What needs to be in place for successful clinical management structures

The success or otherwise of clinical management structures will depend largely on doctors being enticed, not pushed, into the system. Being seen as 'a tool of the system' will be the kiss of death. The following need to

be in place if doctors are to be encouraged into clinical management roles and structures:

- the conviction at every level in the organisation that 'this is the way to go', and that the organisation's existence and future prospects will be more secure as a result;
- the co-operation, interest and support of colleagues, otherwise doctors will see little chance of success for themselves or the proposed new arrangements;
- doctors taking on management roles need to be supported when they go back to full-time medical practice. This implies that:
  (i) there will be a support system for doctors at the professional level, so that they can take up where they left off after their term of office (as, for example, clinical director or clinical co-ordinator) is up;
  (ii) the managerial role they take on will not affect professional relationships when their term of office is up and they go back to full-time professional practice;
- assurances that the necessary information and other resources will be there to allow the doctor to manage. In particular, if support staff are required, they need to be of suitable calibre, and doctors should have an input into their selection.

The goals of management development for doctors

CRITICAL CONTENT AREAS

Until recently, interest in, and demand for, management development for doctors has been stimulated by agencies such as the Institute of Public Administration, which have been responding to needs they identified from their experience within the system. Figure 2 outlines the major content areas identified as crucial by participants, their organisations and management development workers.

The duration of each programme will determine the comprehensiveness with which content areas can be covered; shorter programmes deal with some content areas at an introductory level,

Figure 2

PROGRAMME	CRITICAL CONTENT AREAS							
	Understanding health environment	Understanding organisation's environment	Managing self	Managing other people	Interpersonal skills	Managing change	Technical skills	Projects
18-month HSMDP	/		/	/	/	/	/	/
9-day programme	/		/	/	/			
3-day introduction	/		/		/			
Pilot project	/	/	/	/	/	/		
RCSI/IPA	/		/	/	/		/	/

providing a broad overview and understanding of the management concepts involved. Longer programmes provide an opportunity to develop those areas in more depth, allowing more time for reflection and learning.

Topics included in content areas

Understanding the health environment

- Overview of Irish health care system and issues
- Comparative health systems and issues.

Understanding the organisation's environment

- Purpose, vision, mission and values
- Culture and structure
- Environmental analysis.

Managing self

- Identifying job objectives
- Identifying personal style
- Managing time
- Managing stress
- Writing and presentation skills.

Managing others

- Working in teams
- Leadership
- Managing performance
- Managing conflict.

Communication skills

- Negotiating
- Influencing
- Assertiveness
- Handling meetings.

MANAGING INFORMATION

- Planning
- Costing
- Budgeting and budgetary control
- Option appraisal.

The process of management development

Figure 3 details the methods used on current management development programmes.

Who conducts management development work with doctors in Ireland?

The Institute of Public Administration conducts most of the management development work with doctors in Ireland. Examples include:

- Health Service Managers' Development programme: a multi-disciplinary, 18-month programme;
- Team Development workshops: for multi-disciplinary teams in community-based and psychiatric services;
- Doctors and Management programme: a nine-day programme in three modules for consultants and senior registrars;
- in-house programmes for different disciplines piloting the Clinical Directorates Management Development programme for public sector managers; a four-week, four-module, multi-sectoral programme.

The Institute and the Royal College of Surgeons in Ireland (RCSI) jointly deliver the one-year Diploma in Management for doctors, which is subsidised by the Department of Health. In addition, the RCSI also runs three-day introductory management programmes for doctors at regular intervals.

The Royal College of Physicians in Ireland conducts short, introductory programmes on an occasional basis.

Figure 3

CONTENT AREAS	METHODS USED						
	Short courses*	In-house courses	Multi-disciplinary courses	Use of experience	Action learning	Distance learning	Accredited courses
Understanding health environment	/	/	/	/	/	/	/
Understanding organisation's environment	/	/	/	/	/		/
Managing self	/	/	/	/	/		/
Managing others	/	/		/	/		/
Interpersonal skills	/	/		/			/
Managing change	/	/	/	/			/
Technical skills	/	/	/	/	/	/	/
Projects							/

** Including workshops that are part of a longer workshop.*

Methods of evaluation

Evaluation takes place in relation to the programme's objectives and participants' expectations. Programmes are evaluated by:

- participants
- senior managers
- management development team
- independent evaluators.

PARTICIPANTS

Participants are the principal evaluators of shorter programmes. Through a process of group feedback, they identify, in broad terms:

- what they learned;
- what aspects of their learning they have put into practice;
- what action remains to be taken.

The feedback is used to inform subsequent programme design and content.

On longer (multi-disciplinary) programmes, participants provide mid-programme and end-of-programme evaluations. The mid-programme review:

- evaluates the substantive areas of the programme and the process issues in the action-learning groups;
- identifies emerging needs;
- amends the remainder of the programme, if necessary.

The end-of-programme review evaluates, within a detailed format:

- the degree to which the programme has met participants' specific expectations;
- what they would have liked more, or less, of;
- which techniques and teachers worked, or did not work, for them;
- what participants have been able to do differently, and the strategies used;
- what has been easy, or difficult, about making these changes;
- how the programme helped, or did not help them, with the changes.

Senior managers

Senior managers take part in the evaluation of longer programmes. During the mid-programme review, they are asked to identify the impact of the programme on participants' performance, as well as areas for further development during the latter half of the programme.

The chief executives of the participants' organisations take part in an end-of-programme review, where, in a closed session, they get feedback from participants on their experience of the programme. The chief executives' evaluations are reflected back to a strategy group which oversees the broad thrust of management development for senior health service workers.

Management development teams

On shorter programmes, the management development teams evaluate informally how well the team's objectives were met, and what techniques, activities and teachers worked well.

During the course of longer programmes, facilitators meet regularly to share feedback on the progress of the action learning groups, and to take action on issues emerging from the programme.

Independent assessors

One of the longer programmes has been subject to independent evaluation by a team from the Centre for the Study of Management Learning, Lancaster University. The process included consultations with participants, facilitators, programme organisers and top managers. Results were fed back to the strategy group mentioned above.

Techniques and 'teachers' that work best

Doctors coming on management development courses expect that the techniques used will be the same as those they know from their undergraduate days – plenty of 'talk and chalk' and 'there is one, and only one, right way'. They need to loosen up before they can begin to participate and get involved. The technique that works best for us is to begin with content-based topic, usually by describing a model of management which will be referred to from time to time during the programme, then moving as quickly as possible to a more participative

format, using the doctors' own experience as material for learning. We have found that, if we do not start from where the participants 'are at', we come to grief.

As far as 'teachers' are concerned, credibility is an absolute prerequisite. Facilitators need to be seen as confident and competent, knowing the business, and not afraid to challenge. Having a doctor on the management development team is very helpful, especially at the beginning of a programme. Experts in their own field (e.g. top health service managers or civil servants, other health service professionals) who meet the 'competence' criterion make effective teachers. Most of the learning, however, comes from within the participant group itself. Figure 4 outlines techniques and 'teachers' that work best.

THE FUTURE

Management development for doctors is a relatively new concept. It has been approached on an opportunistic basis, where management development organisations have seen a need and have responded to it. It is now time to adopt a more planned approach. This requires a strategy that takes into account the needs of the doctors themselves, and the goals of their employing organisations.

The formulation of a strategy can be examined under the following headings:

- What are the needs?
- What key people or organisations need to be involved and committed?
- How best can management development be delivered to doctors (and who should be delivering it)?
- How best can the impact of management development be evaluated?

What are the needs?

As we see it, doctors' management development needs can be represented as a continuum that can be divided into four stages of a doctor's professional life.

Figure 4

CONTENT AREA	TECHNIQUES			'TEACHERS'			
	Interactive participative	Role-play	Didactic	Participants themselves	Other health workers	Health experts	Management development workers
Understanding health environment	/	/	/	/	/	/	/
Understanding organisation's environment	/	/	/	/	/	/	/
Managing self	/	/	/	/	/	/	/
Managing others	/	/	/	/	/	/	/
Interpersonal skills	/	/	/	/	/	/	/
Managing change	/	/	/	/	/	/	/
Technical skills	/	/	/	/	/	/	/
Projects	/	/	/	/	/	/	/

1 **At undergraduate level** (probably at the commencement of clinical experience):

- increased awareness of the scope of the public health service, the context within which the health services are operating, the problems and opportunities facing the service generally, and likely trends for the future;
- awareness of the importance of communication for good clinical practice and effective teamwork, plus direct practice (e.g. role-plays, discussions with 'live' patients);
- awareness of the structure of the organisations the students are working in and the roles of other disciplines and professionals (including management).

2 **At postgraduate level** (probably senior house officer):

- personal awareness (e.g. identification of own personal style, contribution to team effort, style of influence);
- personal effectiveness (e.g. time management, stress management, writing and presentation skills);
- interpersonal skills (e.g. behaving assertively, negotiating, influencing).

3 **For recently appointed consultants or senior registrars** who are likely to be appointed consultants:

- management of others (e.g. leading a team, encouraging creativity and innovation, setting performance objectives and assessing them, setting performance standards).

4 **For clinical directors and public health doctors**, in addition to the above:

- working at corporate level;
- working with other disciplines and professionals (e.g. management, finance, personnel).

There will also be, for the foreseeable future, a group of consultants already in post for several years who will have had little, or no,

management development. There is still a need for locally based courses for such people, similar to the central courses being conducted at present, to sensitise them to management concepts, the context within which they are working, and to enable them to enhance their personal awareness and interpersonal skills.

Key people and organisations that need to be involved and committed

The key actors are:

- the Department of Health and the Postgraduate Medical & Dental Board, who have been supportive of management development initiatives to date;
- the medical schools and colleges, especially the deans, who need to be convinced that management is a key skill for doctors, regardless of their specialty and position in the organisation, and that is should have a place in the undergraduate curriculum;
- the doctors' 'trade unions', in this case the Irish Medical Organisation and the Irish Hospital Consultants' Association, whose attitudes will have a significant influence on doctors;
- the chief executives of the health service agencies (e.g. the health boards and voluntary hospitals), who will probably need to commit themselves financially to the costs of management development.

How best can management development be delivered to doctors and who can best deliver it?

The basic options here are:

- content-centred, problem-centred or task-centred.
- centrally based or in-house.
- uni-disciplinary or multi-disciplinary.

We believe there is a place for several different approaches. Figure 5 gives details. The question of *who delivers* is best approached by identifying the teaching/facilitating skills required on a programme-by-

Figure 5

WHAT?	FOR WHOM?	HOW?	BY WHOM?
Awareness of context	All, but especially interns	Lectures, centrally or in-house preferably multi-disciplinary	'Experts'
Familiarity with own	Senior house officers, registrars	• lectures • in-house • shadowing • preferably multi-disciplinary	Organisation staff
Communication skills	All, but especially interns	• interactive • preferably in-house (college) • direct contact with patients • role-plays • uni-discipinary	Whoever has appropriate skills
Management of self	Senior registrars and new consultants	• centrally based • uni-disciplinary • interactive and participative, and ready material • project work	Whoever has appropriate skills (ideally a mix of medical and management development)
Management of others	Clinical directors, medical directors, public health directors	• in-house • multi-disciplinary (with clinical team in fullest sense) after uni-disciplinary beginning • interactive and participative • (partly) issue-based	Whoever has appropriate skills

programme basis. In the nature of things, content areas are probably best addressed by people expert in the field. (This is especially true of the contextual material.) Process issues are best dealt with by experienced facilitators, wherever they are located.

How best can the impact of management development for doctors be evaluated?

Evaluation will be a key factor in the future, not least because of the scarcity of resources and the need to show that management development represents good value for money. Doctors need to be assured that the time they spend on development is worthwhile from their individual points of view. Employing organisations need feedback on the effect the development is having within the organisation. Management developers need to know whether their methods and techniques are producing the desired effect. It follows that any evaluation process will need to address these three different concerns. What seems crucial to successful evaluation is a clear understanding at the outset of what management development is expected to achieve for the organisation, the individual and the management development agency. This presupposes, in turn, that before management development begins, there is a clear diagnosis of needs, at individual and organisation levels. It is not always easy to obtain this, because of the time constraints usually involved and the pressure to deliver on all the parties concerned.

There is another aspect of evaluation that we believe will give rise to concern in the future. This concern can be put in the form of a question: 'Where should the management development effort be targeted within the organisation, in order to produce the maximum impact?' Resources for management development are limited; management development for doctors is 'popular' at present; initiatives with doctors can eat into these resources at the expense of the development of other groups (e.g. nurses, support services). There may be ethical issues at stake here for all concerned.

Italy

INTRODUCTION

The early months of 1993 saw the approval of law No. 502 on the reorganisation of the Italian health care system. This law introduces important innovations regarding the organisation and financing of the National Health Service. Some of these innovations are particularly important:

- Definition of uniform standards of health care service (USHCS) to be guaranteed to all citizens, proportionate with the volume of resources available. Transfers from the National Health Fund (NHF) to the regions are proportionate to this parameter. The objective is to achieve a balance between the various regions regarding availability and accessibility of services (equity).
- Regional administrations have the power to modify the USHCS standards, by either increasing or modifying organisational methods of service delivery. In this case, however, the regions are to cover the costs of any modification through their own resources. The objective is the enhancement of regional autonomy, by making regions responsible for their choices.
- Introduction of two levels of doctor-managers: the first having mainly clinical responsibilities, while the second have primarily managerial roles. The objective is to improve the use of resources, making physicians responsible, and mediating between clinical and economic behaviour.
- Emphasis both on the improvement of service quality through quality control, and on the improvement of relations with users, through the activation of a communication flow oriented towards different types of users. The objective is to bring public structures nearer to users, to humanise medical services and to prepare the tools needed for the steady improvement of the whole sector.

The aim of the law is basically to increase the functionality of the system, reducing the importance given to political administrators and increasing the importance of managerial roles. Consequently, the positions of General Manager, Health Manager and Administrative Manager have been introduced. These positions are held for a specific time period (about five years), and are subject to evaluation and the possible renewal of contracts. These positions create a net separation of

responsibility between the administrative and the health spheres, while at the same time defining organisational hierarchies. Legal autonomy of local health units (LHUs) and hospitals should grant them greater entrepreneurial freedom, while at the same time ensuring the pursuit of economic equilibrium, and the consequent financial equilibrium through the definition of precise managerial responsibilities.

Financial equilibrium is currently the major problem of the whole Italian public system. The Italian NHS, being part of this, has to cope with this issue too.

THE CONTEXT FOR MANAGEMENT DEVELOPMENT FOR DOCTORS

The big issues

The following statistics must be taken into consideration.

Number of physicians in Italy (Census 1989)

Total number of physicians	**4.3 per 1,000 inhabitants**
Hospital doctors	**1.3 per 1,000 inhabitants**
General practitioners	**1.2 per 1,000 inhabitants**
Territorial medical officers	**0.2 per 1,000 inhabitants**
Doctors with NHS contracts	**0.4 per 1,000 inhabitants**
Doctors delivering contracted-out services	**0.2 per 1,000 inhabitants**
Private practitioners	**1.0 per 1,000 inhabitants**

These figures draw attention to the physician typology in the Italian health care system, which is unique in Europe and probably in the whole the world.

Another distinctive feature of the Italian NHS is the constant underestimation of its financial needs, made at a central level. For example, in the second half of the 1980s the financial needs of the National Health Fund (NHF) were underestimated by a variable rate of increase, compared with the final balance sheets of local and regional structures.

Year	Needs L.m.	NHF L.m.	Deficit L.m.
1985	42,047	39,200	2,847
1986	46,675	40,857	5,818
1987	53,538	47,265	6,273
1988	60,864	52,650	8,214
1989	67,448	59,711	7,737
1990	77,718	64,716	13,002
1991	90,136	78,840	11,296

(Source: Department of Health)

The reason for this big discrepancy between central estimates and peripheral balance sheets is due to various factors: different regional patterns of health care delivery, different methods of data gathering (which might even weaken the value of statistical findings), the wide gulf separating those allocating financial resources (central administration) from those managing delivery structures and who, at the same time, have direct contact with the public. To further enlarge this gulf, most of the physicians operating in the public sector (who account for approximately 25 per cent out of a total of 625,000 civil servants in the NHS) base their professional activity on a relationship of trust between doctor and patient. The practice of clinical autonomy, greatly safeguarded by professional organisations, finds no opposition in any clear and explicit regulating mechanism developed by LHU management.

The final result is a big rift between decisions concerning health care planning (where these actually exist), taken at different levels by political and administrative management, and decisions on the effective, concrete use of resources taken by the physicians themselves. The reduction of this rift between macro-decisions and micro-decisions is the main objective and reason for the introduction of management development for Italian physicians.

The first attempt at introducing management development in the clinical system dates back to the beginning of the 1980s. From the very first health reform, it became clear that the quantity of resources needed for the implementation of the law itself would have been huge, due to the structural characteristics of LHUs (and hospitals) and of the envisaged management model, which was mainly based on political intervention, to the detriment of managerial roles. Moreover, it was a question of realising that the complexity of the NHS organisational

framework had greatly increased and it needed adequate responses from the organisational and managerial levels.

A first response, for clinical management, came from SDA Bocconi (Bocconi School of Management), which, in the early 1980s, developed management education courses exclusively for doctors operating in hospital management and in territorial services. Towards the mid-1980s, after a survey of the managerial behaviour of clinicians, the School decided to start an introductory course in management for managing doctors in hospitals. This course mainly focused on topics concerning organisational behaviour, economic evaluations, activity indicators and basic managerial tools. It must be remembered that SDA Bocconi organises management programmes not only for physicians, but also for administrative managers as well as for ward sisters. This integrated approach made SDA Bocconi the most important school of management for the Italian NHS.

Barriers to success

The main difficulties concerning the introduction of a managerial culture to physicians are primarily due to:

- the predominance of the normative approach – a central bureaucratic approach to the organisation of public bodies, taking little or no consideration of historical and cultural differences between the various regional organisational frameworks;
- consequently, the organisation's role is seen as enforcement of rigid laws to guarantee public welfare, instead of as a dynamic instrument to pursue functionality, need satisfaction, and demand development within certain economic constraints (long-term equilibrium);
- since the answers to problems are to be found in laws, there seems to be no need for external contributions to health organisations in the form of organisational advice or educational programmes for the acquisition of management culture, which is increasing as business complexity grows;
- the wrong interpretation of this organisational phenomenon has led to wrong solutions which, in turn, have led to the proliferation of central, regional and local laws and regulations that should have solved the problems;

- a vicious circle was thus started, based on the 'problem to solve, law that provides' approach, which has strongly undermined the functionality of the system and, above all, has greatly damaged the financial equilibrium.

This 'regulation culture' has also affected other public sectors, such as the university sector where, despite a few attempts to establish schools of management for physicians based on the specific knowledge of schools of management combined with the specific knowledge of medical schools, achievements have always been poor due to the strong attachment of the various schools to their specific cultural privileges (problems of organisational power). These institutional constraints have been reinforced by the lack of financial incentives to acquire new skills.

In addition, physicians have strengthened their belief in clinical autonomy as a strong source of negotiating power both towards individual patients and government. What answer can be expected to the following question: what advantage do I get from evaluating the economic suitability of my clinical behaviour, if my patient may negatively estimate my behaviour, while my organisation does not seem to care about it?

Factors for success

The main factors that could play an important part in the positive development of cultural change can be summarised as follows:

- the new culture of territorial services developed by young physicians, as not only a clinic-oriented professional activity, but also as an activity directed to the management and rationalisation in the use of resources;
- a strong international pressure on the traditional culture of the clinical physician, linked to the quality of treatment, through the establishment of scientific associations, the publication of specialised reviews, and organisation of various conventions;
- the strong competiveness for securing the resources available which are scarcer and scarcer compared with the variety of possible uses;
- the obscure and non-structured orientation of Law No. 502 towards the privatisation of part of the NHS, or at least towards the introduction of (guided) competitive mechanisms within the Italian NHS.

The success of the individual doctor-manager appears to be strongly linked to certain conditions, which, although they may not be sufficient, seem at least to be necessary. These conditions are:

- an incentive system capable of responding to the motivational needs of individual doctors and of the social group they belong to, and which at the same time takes into due account the LHU aims and the needs of the user. It should be a system that links efficiency, effectiveness and service quality;
- an information system that supplies the most suitable information for the decisions the doctor has to take daily; a system that gives advice on the most suitable behaviour at both the (individual) specialistic professional level and the (group) managerial level;
- the incentive system and the information system could be integrated in the clinical budget, through which it might be possible to carry out, at the micro-level, short-term planning, control and evaluation of the activities carried out and of their costs, efficiency, quality and the degree of user satisfaction.

Career paths for doctors in clinical management

There are three main categories:

1 physicians practising in the NHS
2 general practitioners
3 physicians practising in private clinics, delivering contracted-out services.

With regard to group 3, freelance relationships or private law employment contracts (whereby remuneration and social-security treatment are similar to those of any private enterprise) are the most frequent, except for the position of health manager. For this position, the physician must have followed a predefined career path and must have achieved predefined specialisations.

With regard to group 2, no particular career paths are envisaged, since contracts between the NHS and GPs are not an employment relationship but are based on a convention defining payment rates (per patient) and the type of services to be delivered. Pay rises are gained through length of service.

As for group 1, there is only one contract for physicians employed in the Italian NHS, regardless of the type of work they carry out. This means that all physicians practising in territorial services and in hospitals (acute care, chronic care) are subject to the same normative system as far as career development is concerned. There are three positions in the medical professional hierarchy:

- the position of junior doctor, attainable through sitting special postgraduate exams. The minimum requirements for exam candidates are:
  (a) degree in medicine and surgery,
  (b) qualification to practise the professional activity,
  (c) candidates must be under 40 years of age,
  (d) candidates must be signatories in the professional register;
  the only exception regards radiologists and anaesthetists who have to be specialised even to attain the position of junior doctor;
- the position of senior registrar is attainable through taking specific specialist exams. The requirements needed by candidates are, in addition to the previous requirements:
  (a) at least five years' experience in the specific branch of medicine covered in the exam, *or*
  (b) already being specialists in that specific branch of medicine. This means that, for example, if a physician has practised as district medical officer (i.e. as a civil servant) for at least five years and is a fully qualified cardiology specialist, he/she can sit the exam for senior registrar of cardiology exactly in the same manner as a junior doctor in cardiology who is not yet specialised but has at least five years' experience.
- the position of consultant manager (in some ways similar to the position of the British consultant, only with greater managerial responsibility). This position too is attainable through taking a specific specialist exam (examination sessions are generally held every two years, sometimes more frequently depending on various political factors). The requirements for candidates are the following:
  (a) the same as those for aspiring senior registrars;
  (b) to have already passed the official state exam required to become a qualified consultant;
  (c) specific career requirements, such as experience in a specific branch of medicine;
  (d) specific qualifications.

Admission to the exam is not formally linked to (i.e. it does not determine, nor is it determined by) the number of available consultant positions in the specific branch of medicine of the candidate.

Admission to all these examinations is based on a point system applied to each candidate's qualifications (publications, specialisations, career seniority, etc.). The results achieved during written and oral exams, practical tests concerning the candidate's specific branch of medicine, etc., are added to the initial sum and the final score is thus calculated. The composition of the board of examiners differs for each clinical position.

Exams for the position of consultant have to test not only specific specialist skills, but also the organisational and managerial knowledge of the candidates aspiring to the position of consultant manager. By law, consultants have the power to organise ward personnel, laboratory technicians and rehabilitation personnel in the long-term hospitalisation wards. The same organisational accountability is given to consultant-managers of territorial services, who cover even more managerial tasks, since their clinical activities are fewer than those of their colleagues, the hospital managers. The structure of the Italian hospital is quite important too, since the position of health manager was the managerial link between consultant managers and the political decision-making bodies until 1991. In fact, it can be said that although ward organisation is in theory a good answer to the decentralised management of complex hospital structures, a consultant-manager's clinical tasks and responsibilities prevail by far over managerial ones.

When there is no managerial support to ward activities or territorial services, a traditional medical culture persists which favours the pursuit of the best for individual patients, instead of the 'overall needs overall approach' to balanced resource management, which is the main focus of general management. To overcome these limits in the Italian health care system, Law No. 502 foresees the reorganisation of the role of doctor-managers in order to pinpoint positions covering mainly managerial tasks (second-level doctor-managers) and those mainly clinic-oriented (first-level doctor-managers), and identify the tasks carried out by the two different categories of managers. The major change Italian doctor–managers will have to face is the temporariness of the position of second-level manager (generally a five-year contract), as they are used to having a secure position. To attain this position candidates have to take a recently introduced national exam. After their first term of appointment,

contracts can be renewed following an evaluation of the results obtained by the doctor-manager and how he/she managed the constraints on allocated resources. If a contract is not renewed, the second-level doctor-manager still holds the title of second-level doctor–manager, even if he/she no longer holds this position. Second-level doctor-managers are entitled to a specific financial treatment, which can be negotiated with regard to some of the items making up their salary.

MANAGEMENT DEVELOPMENT GOALS FOR DOCTORS

In the Italian context, there are great differences in the need for management education for doctors. This is due to their different levels of professional experience and to the position they hold within the Italian NHS and, more specifically, within the various health care environments (LHUs and hospitals). In this section, we will examine the objectives of management education; it is necessary to distinguish between what managerial education should be and the current situation at the various levels along the continuum (see Figure 6).

At both the undergraduate medical student and graduate training levels, education on aspects of management should be limited to sensitisation and support aimed to make students realise the importance of acquiring basic managerial skills in order for them to be able to solve management problems. This should be implemented right at the very beginning of their university course. As a result, the need to integrate managerial tasks with professional tasks would be highlighted (the latter do not necessarily help solve management difficulties doctors will have to deal with in the course of their activity).

However, the Italian educational system only envisages a 20-hour course in health care economy as part of the whole university curriculum for a degree in medicine or for the postgraduate specialisation courses in hygiene.

As for consultants, senior registrars, and clinical and medical directors (i.e. consultants responsible for an operative unit), the objective to be pursued through management training lies in introducing doctors to the most useful aspects of management for management improvement, in terms of both efficacy and efficiency in the use of resources. The specific objectives can be identified as:

Figure 6

	METHODS FOR SENSITISATION TO MANAGEMENT	MANAGEMENT DEVELOPMENT PROGRAMMES (COURSES THROUGH TO DEGREE PROGRAMMES)	TRAINING PROGRAMMES SPECIFIC TO A PARTICULAR ROLE
Under-graduate medical students	Lectures	Health economics course	
Graduate training level	Lectures, project work and thesis	Hygiene specialisation; health economics course	
Consultants, specialists, hospital physicians	Lectures, case studies, brain-storming, role-playing, fieldwork, tutorials, testimonials		Management courses for hospital physicians (short courses)
Physicians in non-hospital practice/GPs and others	Lectures, case studies, brain-storming, role-playing, fieldwork, tutorials		Management courses for non-hospital physicians (except GPs) (short courses)
Clinical/ service directors	Lectures, case studies, brain-storming, role-playing, fieldwork, tutorials, symposia		Management courses for medical and clinical directors (long and short courses)
Medical directors	Lectures, case studies, brain-storming, role-playing, fieldwork, tutorials, symposia		Management courses for medical and clinical directors (long and short courses)

- increasing ability to solve organisational and managerial problems;
- increasing ability to interact with other physicians operating at the same level of responsibility;
- developing ability to manage and co-ordinate the various professionals involved in the diagnosis and treatment processes;
- promoting the development of new kinds of services for the users;
- fostering organisational integration.

Another objective of management development training for this category of physicians could be the acquisition of the managerial skills necessary to carry out managerial roles with greater responsibilities (for example, LHU or hospital general managers).

With regard to the category of physicians in non-hospital practice, the aim here is to highlight the peculiarity of the Italian system where, at least until 1993, GPs played a marginal role in terms of managerial responsibilities, due to the independent professional relations between them and LHUs. The peculiarity of these relations has blocked the development of any educational activities for GPs, unless they were focused on aspects closely connected with their professional follow-up activities.

The recent law on the national health service will cause remarkable changes in the relations between GPs and the NHS system, both in terms of functions and services demanded from them, and in terms of payment for their services. Consequently, GPs will have to develop specific managerial skills in the near future. In particular, they will have to be able manage a budget; to negotiate the purchase of intermediate health care services for their patients (e.g. laboratory tests, X-rays, appointments with specialists); to develop their attitudes positively towards teamwork (e.g. associated groups of GPs, and also integrated structures between GPs, radiologists and laboratory technicians). Another type of physician in non-hospital practice is represented by doctors delivering territorial services for LHUs (e.g. public health and psychiatric services, school doctors, health districts). Management education should encourage these doctors to acquire the knowledge and skills necessary to:

- control external structures delivering health services;
- plan and control GPs' activities;
- plan and control health territorial service interventions;
- integrate activities carried out in hospitals.

As far as hospital and health administrators are concerned, the main objectives of management education lie in supplying the necessary know-how to carry out managerial functions in highly complex structures. In this case, management education activities are similar to those adopted in general management educational programmes.

Major content areas taught at each level along the continuum

As shown in Figure 6, three main groups of doctors can be identified that would benefit from managerial training:

1 doctors terminating a degree course in medicine and those specialising in hygiene;

2 doctors working within hospital structures and doctors delivering territorial services (junior doctors and senior registrars) who are not officially in charge of their units;

3 hospital directors, heads of department and heads of territorial services who are officially in charge of their units.

In the first case, current training courses cover aspects of:

- medical statistics
- health economics
- epidemiology
- health organisation
- health legislation.

These courses are primarily intended for newly graduated doctors who have chosen to follow a postgraduate course in hygiene.

Training of medical students close to the end of their undergraduate or postgraduate studies, and as yet not working full time in the profession, centres on their individual acquisition of knowledge. Hence, in taking the necessary steps to meet organisational requirements, a link should be sought between results obtained in university training of young doctors and the general requirements placed on doctors by hospitals, the LHU and similar organisations.

As for the other two groups (2 and 3 above), the general subjects cover:

- organisational structure of health care services and wards;
- organisational planning;
- planning and control systems;
- human resource management and management of organisational conflicts;
- logic and information-processing methods.

Training courses for heads of territorial services place emphasis on relations with the outside environment, while in training courses for heads of diagnostic units and diagnostic services, emphasis is placed on methodology and ways of checking and evaluating activities. Quality is a further content area common to these two groupings; this covers 'quality' interpreted in the medical sense (medical audit), and 'quality' interpreted in the more general sense of organisational quality (total quality). Training at this level should in theory be aimed at satisfying the development and growth requirements of the single doctor as well as satisfying the development and organisational requirements of the LHU. An example could be the development and diffusion of an adequate managerial culture among physicians, and/or changes in mechanisms and decision-making processes exclusively based on a professional logic typical of the various hospital units.

In actual fact, however, there seems to be a proliferation of programmes fuelled by the interest and desire to learn of individual doctors who attend specific courses on their own initiative. This form of managerial training obviously satisfies only individual needs, while not really having a concrete effect on the functioning of the LHU or single hospital unit.

All the same, especially in northern and central Italy, a global approach has recently emerged, based on the analysis of the training requirements of the various LHUs. This approach is manifested in the growing number of management training courses for doctors mostly carried out on hospital or LHU premises. These courses are often, if not always, co-ordinated by the LHU internal training department, and are substantially organised into three basic types:

- standard training courses introducing general management principles;
- courses aimed at developing greater awareness of the specific educational needs of the unit or structure holding the course;
- seminars on specific subjects considered to be particularly relevant to that unit or structure.

Tailored management courses for doctors offer greater advantages than generic courses in terms of training effectiveness; these, in fact, allow:

- the fostering of a homogeneous managerial culture among LHU personnel;
- the satisfaction of specific training needs of medical personnel, including those inherent to particular management projects and changes currently under way in the specific LHU;
- a higher number of personnel acquiring managerial culture.

Management training for doctors (both briefings and courses held on LHU premises as well as those held directly at the training schools) is specifically aimed at doctors only. Courses for mixed professional groups (for example, nurses, laboratory technicians, administrative personnel or managers) are rare. Mixed classes are preferred only when training participants to co-ordinate entire health service structures, or for subjects destined for general management, or, at any rate, high-level management. However, here too, classes are mainly made up of doctors and administrative directors. There are principally two reasons behind limiting the mixed-class approach:

- first, the high level of conflict that normally exists within the Italian health service between doctors and administrators. Both sides identify in their opponents – and particularly in the way they carry out their tasks and reach decisions – the principal cause of organisational malfunctioning within the LHU. For this reason, the mixed-class approach in managerial training could lead to the creation of a classroom environment that even the most expert of lecturers would find difficult to manage, thus reducing the effectiveness of the training process. Particularly in the case of tailored courses, participants might transfer conflictual situations

existing in their organisations to the classroom, consequently reducing their level of participation and involvement. This would be particularly evident in the basic introductory courses on management skills.

- second, problems could arise from the different level of legitimisation and the different organisational status that different professionals operating in the health service currently enjoy. We refer in particular to the lesser status attributed to the non-managerial administrative personnel, technical staff and nurses. Here too, mixed-classes might reduce the effectiveness of managerial training. There is a risk that medical personnel might be induced to regard managerial duties as primarily administrative functions, to be delegated to personnel in other sections and departments, and which, at best, only require their scanty attention.

The process of management development

Considerations regarding the process of management development to choose should bear in mind the following points:

- the didactic methodology used;
- the lecturers involved in management training courses for doctors;
- the methods used to evaluate the effectiveness of the training programme.

In management training courses for doctors, numerous didactic approaches are available. In undergraduate, postgraduate and post-university courses traditional methods are preferred. Didactic techniques for training consultants, senior registrars and territorial service doctors cover both traditional-type lessons as well as active methods such as: brainstorming, case discussion, role-playing, simulations with the aid of a personal computer, fieldwork, dissertations and tutorials on specific applied projects. Finally, we should mention the growing number of conventions on management subjects, organised by doctors operating in wards and hospital services. These conventions are often conceived and organised by group associations, as for example the National Association of Surgeons/Paediatricians.

Management training for doctors at different levels is principally carried out by:

- lecturers from schools of management specialised in developing public administrators (e.g. SDA Bocconi, Scuola di Lucca, Galgano, Formez, IPSOA);
- university lecturers and professors at different levels (full professors, associate professors, research fellows, lecturers);
- management consultants (mostly from outside the medical profession);
- public employees working as consultants and lecturers for public and private training agencies (e.g. Italian Health Institute, Cresa);
- testimonials by doctors working in the NHS structure.

In Italy, the evaluation of the effects of management training for doctors is an open issue. First of all, the evaluation is not structured and non-standardised, being without any precise reference methodology. One way of finding out whether the course has been successful is highlighted in the following example. In 1991, a course on general management was held in a LHU. The following year the same LHU requested a 2–3 day follow-up course developing certain aspects only briefly covered in the first one. Another way of evaluating a course consists in accompanying traditional training activities with practical fieldwork and experimentation which directly involve doctors in purely managerial roles relating to experiences in Italy. This approach has been used with subjects related to:

- VRQ and quality control;
- total quality;
- planning and control systems;
- definition and planning of evaluation indicators of medical activities;
- planning and revision of information flows at ward or service level.

In this case, training is strictly connected with practical tutorials, with the lecturer following and directing the work of the doctors involved in the training process.

The ways and means of evaluating the training activity as such are better defined and more consolidated. Here the participants evaluate the

course they have followed using specific information aids (questionnaires, charts). The evaluations can cover a variety of aspects:

- subject-matter dealt with during the course;
- the methodology used;
- the lecturer's teaching abilities;
- the didactic material distributed.

For short courses, the evaluation is only carried out at the end of the programme, while for longer courses a series of intermediary evaluations are also carried out by way of a debriefing of those taking part. The consolidated experience in this field helps define a didactic methodology that is best able to meet the needs of doctors in the different subject-areas of teaching (see Figure 7).

In tailored courses, a division of the day into sessions or half days covering different subject-areas (e.g. a session on management control, one on activity evaluation, one on technology assessment) is preferred. In courses carried out on LHU premises, an entire day is normally dedicated to one subject.

THE FUTURE

Italy is currently going through a period of great uncertainty in the health sector. This is mainly connected, on the one hand, to the macro-economic need to contain the public debt, leading to a reduction of the overall resources allocated to health care and, on the other hand, to the implementation of the health service reform as laid down by the Health Minister, De Lorenzo – a reform that will bring profound changes to the entire environment in which future health units will operate. Both of these factors will affect the issues related to managerial training for physicians.

In the first instance, the containment of financial resources will imply (all other conditions remaining the same) an increase in the need for managerial skills in managing declining resources. This will not only be the case at general management level, but also and more significantly at doctor-manager level where these will have to 'make the best of things' and integrate their own professional skills with specific management skills. This will not only be the case at hospital-doctor

Figure 7

Subjects / Teachers	Organisational theory, personnel management	Management control, DRGs planning	Quality issues, behaviour
Business administration	Fieldwork, tutorials, lectures	Lectures, case studies, role-playing	Lectures, tutorials, case studies
Specialised physicians	Lectures, role-playing, case studies	Tutorials, fieldwork	Fieldwork
Testimonials and experts	Lectures, law analysis	Lectures, case history	Lectures, case history

level, but will also and above all affect GPs. Similar to the British model, the latter will in fact be made responsible for the independent management of their own financial budgets, while guaranteeing minimum levels of assistance and health care to their patients.

The health reform also implies a drastic overhaul of the roles performed by doctor in hospitals. Even though the two levels of doctors (the first, having a primarily specialist function, and the second, being responsible for the overall running of the unit) follow the existing organisational model (as laid down in Law No. 6833/78), the role of the doctor-manager constitutes a radical change. The second level is in fact limited to a given period (five years) and is renewable following evaluation of results obtained during the first term (where 'results' means performance both in terms of professional and organisational results obtained). To be eligible for a managerial role, doctors must be qualified. Having attended special training courses covering organisational and managerial subjects could lead to this qualification.

What are the implications of this line of development on the managerial training of doctors? Two significant implications are currently emerging:

- a growing interest shown by medical faculties for the development of courses related to health care management. It is evident that

moves are being made to strengthen postgraduate schools in hygiene and health economics. Some of the most prestigious Italian medical teaching establishments and universities are in fact moving in this direction;

- a significant increase in the demand for training on the part of doctors who are already working at various levels within the Italian health service, and in particular coming from consultants and senior registrars.

In both instances, it will be important to plan future training programmes in such a way as to allow an effective link between the training of doctor-managers and the needs of the organisation where they operate. In particular, it will be necessary to proceed, on the one hand, to a substantial broadening of the type of training initiative specifically designed for doctors, and on the other hand to a revision of the teaching content of existing courses.

The first instance poses the problem of thinking up new programmes capable of satisfying the requirements of professionals who have never received any kind of formal management training (here the British and Spanish experience would show interesting examples). In the second instance, it is a question of giving more time to training in specific subjects such as budget management, DRG system, service management, economic evaluation methods of health service activity in general, etc. These represent the principal innovative management tools with which health units and heads of department at various levels will have to come to terms in the immediate future.

Apart from the subjects already mentioned in the training curriculum, two other aspects of health care management must be included in future courses. First, relations between the LHU and the outside environment and, second, strategic planning in health organisations. These subjects are already included in top management courses, and will take on greater importance for doctors operating in public hospital structures, due to the predicted arrival on the Italian health sector scene (from 1995 onwards) of sizeable private organisations (private health coverage similar to the HMO system in the USA, health insurance and professional associations) which will considerably modify the current functional and competitive logic of the sector.

With regard to how courses are structured and organised, there seems to be no significant need for changes, at least in the short term.

The Netherlands

THE CONTEXT

In the Netherlands physicians have management positions mainly in acute (academic and non-academic) hospitals, psychiatric hospitals, nursing homes and rehabilitation centres. The discussion in this paper will be restricted to these groups. Medical managers in other parts of the health care sector (like social medicine, public health or health insurance) or in the private sector are not taken into account.

In this paper a distinction is made between two types of managing doctors. There are doctors combining management activities with medical practice, and others in full-time management positions who have previous medical practice experience as an entry condition. The difference between the two types is important for planning and analysing management development for doctors.

For the first type of doctors, management activities are only one element in a variety of professional tasks. The element can be large or small, depending on one's formal position in the organisation. The growth of these managerial tasks is mainly a side-effect of the professional career and not the result of a deliberate choice. The second type of doctors has made an explicit decision to stop medical practice and to use their experience in the health care system in management activities.

Career patterns

In 1990, there were 169 acute hospitals and rehabilitation centres, 80 psychiatric hospitals and 326 nursing homes in The Netherlands. Most of these institutions are owned by foundations. Health care money is not raised through taxation, but by (mainly social) insurance fees. In 1990, there was a total of 6,379 general practitioners and 12,210 medical specialists. General practitioners work in solo or small-group practices. On few occasions they switch to full-time management in acute hospitals.

In The Netherlands, nursing-home medicine and rehabilitation medicine are registered specialties. Their specialists are employed on salary, as are psychiatrists who work in psychiatric hospitals. For these three specialties, medical practice from the first day on implies a management role. Patient care in their institutions is organised around multi-disciplinary teams, the specialist being the chair of the team. The next career step for these specialists is a position that combines patient

care and the management of a group of specialists working in the institution (e.g. as head of the medical service department). The third and last step is management at the board level. Depending on the size of the organisation, this can involve a part-time or a full-time job.

A related career pattern is found in the academic hospitals where one can move from full-time patient care (without formal management responsibilities) to positions with an increasing volume of management tasks, like head of a ward or an out-patient unit. The position of head of a clinical department is outside this career pattern. It is occupied by clinical professors, appointed jointly by the hospital and the medical school. The appointment here is based on a variety of functional requirements, predominantly in the area of clinical research.

In the Netherlands, most specialists in acute hospitals work on a fee-for-service basis. There are contracts that admit a restricted group of specialists to each hospital. Specialists of one specialty are forced by these contracts to work together in group practices. There is no formal hierarchy between members of these group practices, although there always is an informal vertical differentiation because of differences in seniority. Recently, in larger group practices (of specialties like internal medicine and surgery) a division of labour of internal and external managerial tasks has been developed.

Internal management of group practices basically is management of the group dynamics and of decision-making. The focus of external management is on relationships with other specialty groups and the hospital management. By contract, all specialists admitted to a hospital are members of the medical staff. The staff make decisions on organisational and strategic matters concerning medical practice and the relationship between medical practice and the overall hospital organisation. The staff have a board that negotiates with the hospital management on subjects like the hospital strategy, investments, budgets, appointment of new specialists, etc. So board membership requires a wide range of complex management knowledge and skills. Frequently these requirements are not met, partially because membership is by rotation and is not a career choice.

Some specialties (e.g. radiology, pathology, bacteriology, pharmacy and medical chemistry) work with smaller or larger facilities, owned by the hospital. Their managerial tasks are more complex than those of other specialties. Formally, hospitals require the group practices in these specialties to appoint one of the specialists as the medical head of the

facility. These specialists have to share management responsibilities with administrative facility managers who are on the payroll of the hospital. So in these specialties, over the years a tradition has developed to handle the interface between the hospital organisation and the medical practice.

Target groups for management development for doctors

On the basis of the foregoing description, we can identify several target groups for management development for physicians in The Netherlands:

- *general practitioners*. They seldom have complex managerial tasks and have no management career pattern if they stay in practice. Some shift their careers towards full-time management positions, mainly outside hospitals;
- *specialists with team leadership responsibilities*. Psychiatrists, rehabilitation specialists and nursing home doctors chair multi-disciplinary teams and can have a career as head of a medical services unit or (part-time or full-time) medical director;
- *specialists with certain facility management responsibilities*. Laboratory specialties and radiology have managerial responsibilities for facilities owned, and for personnel employed, by the hospital. However there is no real career path here;
- *all hospital specialists*. In group practices they share internal and external management tasks. External tasks focus on managing the relationships between other specialties in the hospital and the hospital management. There is no career pattern in this. Some specialists take on managerial tasks as members of the board of the medical staff. There is no career pattern in this either, and the tasks are always combined with professional medical work.

In summary, it can be said that there is no structural career path present in The Netherlands in the area of medical management. There are no formal functional management requirements for managerial positions held by physicians. Doctors qualify for managerial positions predominantly by virtue of the managerial experience related to their medical career.

The big issues

In 1983, the funding of Dutch hospitals switched from an open-ended system to a budgetary system. Later, funding of other health services switched to a budgetary system too. For managers of health care institutions this implied a change in management tasks. Before the switch, management primarily was an activity that adapted the organisation to medical progress and growing demand for medical care. After the switch, balancing scarce resources between medical progress and growing demand for services became a major managerial activity. In the meantime, the principles of organising demand and supply in the health care sector have been changing. The role of the Government is becoming less prominent, and laws and regulations are introduced to further competitive elements and market behaviour of health suppliers and insurers.

Two issues are prominent now. First, there is the necessity to develop market-oriented management skills and attitudes, not only at the level of boards of directors, but also at the middle-management level. This applies to medical as well as non-medical managers.

The second issue concerns the relationships between medical staff and the management of hospitals. A lot of activities in the hospital organisation are induced by the medical activities of specialists. Under open-ended funding, the hospital expanded its facilities and resources as a result of growth in medical activities. Under budgetary conditions, it is urgent to create a balance between the expansion of medical activities (and the demands these activities respond to), and the restricted resources and growth potential of the hospital organisation. In order to get that balance it is necessary for medical specialists to become more sensitive to the relationship between medical services and resources available. It is also necessary that specialists become more sensitive to questions of optimal use of resources, that is to the relationship between efficiency and quality, and to questions of cost-effectiveness.

There is also a third issue. Over the last decades, the complexity of health care organisations has grown enormously. A side-effect of this is that higher demands are imposed on the organisational behaviour of everyone functioning in these organisations. Much has been invested in the training of nurses in this area. Medical doctors are not at all trained in this respect, during their professional training programmes. So until now, managerial – and, more broadly, organisational – behaviour of medical doctors has reached its current level by mainly trial and error.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

There are no formal training programmes for doctors in The Netherlands who want to change their career and become full-time managers. At the moment, one mainly qualifies for medical management positions by building up a record of managerial activities through participation in working parties and committees inside the hospital, or in local or national professional organisations. The absence of a training track is related to the absence of a clearly structured career pattern in medical management. There are no initiatives to develop such a pattern. The independent position of Dutch health care institutions is a large obstacle to this.

There are several initiatives to train specialists for managerial tasks. Specialty training in The Netherlands takes 4–6 years and five specialty boards offer a two-day course in hospital organisation and management, while others are developing plans to do the same. The general feeling in the boards is that this is an important thing to accomplish. Erasmus University and the Dutch Association of Medical Specialists offer a post-registration programme that consists of four two-day modules, a fifth, one-week module is being developed. This programme offers a general introductory course, fit for every specialist. The other modules especially prepare members of medical staff boards for their tasks. The programme also offers a one-day introduction to hospital organisation issues for residents. The Dutch Health Care Federation (Nederlandse Zorg Federatie) offers training for mixed groups of workers in hospitals, including specialists. The Federation also offers training for residents.

Apart from these initiatives, training is offered to specialists as part of organisational development programmes in hospitals. Many hospitals are involved in mergers or decentralisation processes, and as a part of these changes specialists are trained – as a group or in mixed groups with other hospital workers. Here again the Dutch Health Care Federation is active, as are many consultancy firms.

There is no formal legal framework that prescribes specialists to participate in management training. However, three years ago, the Dutch Society of Medical Specialists formally stated in an agreement with the Dutch health insurers that specialists had to participate in management responsibilities in hospitals. One of the consequences of this agreement

was that the specialists felt a need for formal management training – as offered now by the Society in collaboration with Erasmus University.

GOALS

Because there is no single formalised national approach to management development for doctors in The Netherlands, institutions and professional associations follow their own policies and, by doing so, create a diverse pattern of training activities. However, most activities can be classified as pursuing the following goals:

(a) introduction to basic organisational thinking and behaviour;
(b) introduction to basic financial management;
(c) introduction to basic strategic management and hospital strategy development;
(d) introduction to basic quality management and management of efficiency of hospital services;
(e) preparation for managerial roles of board members of the medical staff;
(f) in-depth training on the subjects mentioned above.

Format and teaching methods

Items (a) and (c) are offered in formats that address individual as well as organisational needs. Items (b), (d) and (e) are offered by profit-making, professional training organisations at national level, with open subscription. An open-subscription course on item (f) is at the developmental stage.

While almost all training activities are in small groups (12–18 people), teaching methods vary from lectures to problem-based learning, in combination with a workshop format. Generally, interactive teaching methods are most effective and user-friendly. However, as doctors themselves are used to a lecture format in their professional postgraduate educational activities, they often expect the same of management training.

There is no external evaluation of the quality and effects of the courses, nor is there a systematic assessment of educational results of participants. Some trainers use questionnaires to get participants' opinions on the programme design and results.

Teachers

Management development training is given by a large variety of people from an academic or consultancy setting. Effective trainers are able to present theory in combination with its applications in practice. Ineffective academic teachers offer theoretical notions without making it clear how they can be used in practice. Ineffective consultants offer practical rules without clarifying the theoretical framework behind them. In the first case, participants will not learn anything that might have an impact on their organisational behaviour. In the second, participants learn tricks that often worsen their organisational behaviour.

THE FUTURE

Medical doctors have a growing interest in participating in management development programmes. Given the decentralised character of Dutch health care, demand for training programmes will be expressed mainly at the individual or hospital level. Responding to this growing demand, an increase in the number of courses with open subscription can be expected, as well as a proliferation of in-company training. However, the supply capacity will be limited by the number of qualified trainers.

At the moment, efforts are being made to create national training programmes with open subscription. The number of doctors willing to participate in these programmes at their own expense is rather small, so the success of these programmes will mainly depend on the willingness of third parties (hospitals or professional groups) to pay for them.

Scotland

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

Introduction

In Scotland, with a population of 5.1m scattered over a relatively large area, few doctors were involved in direct management of health services until the recent Government White Paper on 'Working for Patients'. In the past, a few doctors, mainly psychiatrists, had a management function as superintendents of large institutions. In addition, directors of public health also had an implicit management function which was variably recognised by the incumbents.

The main purpose of the introduction of general management and of recent NHS reforms has been to devolve responsibility for resources downwards towards the patient, at the same time increasing accountability and audit of clinical activities. One consequence is that many hospitals have started to develop a clinical directorate structure. As part of the devolution downwards, hospitals have been encouraged to become more independent of the boards who formerly managed them, by becoming hospital trusts. In essence, this gives hospitals and other providers, for example community care, a certain degree of flexibility. Trusts should concentrate on being providers of health care, through contracts with health boards and, increasingly, certain groups of general practitioners.

General practice has also been affected by a parallel set of reforms, initially introducing clearer contracts for their activities as independent practitioners and providers of primary care, and more recently by giving an option to become fundholding practices. This gives them the ability to purchase approximately 30 per cent of mainly non-urgent clinical services from providers such as NHS hospitals, but also from the private sector.

The second, and perhaps less important, reason for encouraging doctors to take some interest in management in Scotland is related to the introduction of general management in the National Health Service in the mid-1980s. It is apparent that the wider the pool of potential managerial talent from both within and outwith the health service, the better managed the service is likely to become. Removing real and

perceived barriers to the participation of doctors widens the field for recruits to senior management posts in the health service. However, one must also ask about the motives for some doctors to enter into a management role. Is it to develop their own career and clinical practice? Is it to assist in a perceived need for organisational change? Is it to redirect their career from medicine into management? Is there a political motive, to do with the recovery and retention of professional power?

The concept of introducing doctors to management began by setting up courses in Scotland in 1968. These have continued in various forms until the present. Initially they were aimed at consultants shortly after appointment, and were primarily intended to provide management appreciation of the health service as appropriate in the decades during which the courses were run. More recently, the programme was reconstituted and became rather broader-based, in line with the health service reforms and the increasing emphasis being made on the identification and training of clinical directors, and also medical executives, who are the senior medical managers in hospital trusts. Courses change in content as the roles, accountability and responsibilities of clinical directors are clarified. Functional management is still strong in the NHS, and breaking this down provides considerable challenges for clinical directors, and for the managers of hospitals and other units. There are different needs for training doctors based in the acute sector, and those sectors in which community-based services, including psychiatry and geriatric medicine, are important. Defining these different needs takes time, and is not completed at the time of writing.

In general practice, recent contractual reforms have provided incentives for maintenance of postgraduate training in clinical areas and also in management. Basically, this requires that at least four half-days are spent in management training over a five-year period for certain additional payments to be made to the practitioners.

The major barriers to success

The major barriers to success were initially indifference and, in some cases, frank hostility arising from the manner in which the hospital health service reforms were initially introduced. Finance has not usually been a major problem for most doctors wanting to do management training although in some health boards this has been more difficult than

in others. Finance may become a difficulty for some trusts. Finding time away from clinical duties can also be a problem for some clinicians. A clear distinction has however been made for hospital doctors, which means that time taken on management courses is not subtracted from time allowed for professional and other postgraduate activities, such as the annual meetings of national clinical societies.

THE MAJOR FACTORS FOR SUCCESS

Major factors for the success of these efforts are that in most cases management training has been provided through the postgraduate medical network, both for general practitioners and for hospital doctors. This provides medical 'ownership' of the process and also, to some extent, the style of provision. It is possible that style is more important than might be realised in that the general pattern of taking people away for residential courses (or at least away from their hospitals) has proved to be beneficial, as it provides 'space' which is rarely otherwise available in busy clinical lives. An important factor also has been the strong support of the Chief Executive of the National Health Service in Scotland over the last three years.

Career paths for doctors in clinical management

Advice and role models for the career progression of doctors who wish to take on increasing management roles are only gradually being developed. The natural path following the initial appointments will be for hospital consultants to become clinical directors, and for some of those to become medical executives of trusts. It is highly likely that a few will leave clinical medicine and become general managers of units and boards. There are one or two examples of this already with consultants mainly from a public health background in this role. In general practice, there seems to be less of a pattern developing, as principals have always had a management role. General practice is run by independent practitioners responsible for the organisation and delivery of primary care services. However, there is likely to be at least a management advisory role for certain general practitioners in two areas – one, to management involved in running family practitioner services, and the other, to the pharmaceutical advisory committees (monitoring function) in general practice.

As far as contracts are concerned, the main constraint is likely to be that of the amount of support needed by clinical directors to help them to manage their resources properly without losing an excessive number of clinical sessions. There may be contractual problems in terms of managerial salary scales when doctors decide to become unit and general managers, particularly those in senior positions who have salaries currently boosted by merit awards, or by private practice.

The major obstacles to success are partly (as indicated above) to do with support staff and the availability of appropriate time away from clinical services, and partly a reluctance of a considerable number of doctors to take on managerial roles when they are currently employed in providing an excellent clinical service to which they are committed.

The major factors needed to support doctors in clinical management roles are, clearly, adequate time and support staff, a commitment from the top in terms of general management and indeed chief executives, and the general willingness of their colleagues – both in medicine and other professions – to accept their management role, for example as a clinical director.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

UNDERGRADUATE STUDENTS

Undergraduate students in Scotland have some introduction to health service structure, and variably to some aspects of management, particularly purchasing. This is normally provided within the Public Health course and does not have any specific, identifiable exam. As far as graduate doctors are concerned, for example house physicians up to registrars, there is virtually no training provided for these groups at present. Proposals are in hand to provide some experimental courses for senior house officers and registrars within their hospitals. Nonetheless, a few registrars have attended existing courses principally aimed at more senior individuals such as senior registrars and consultants.

Senior registrars

Senior registrars have had a number of 'within specialty' courses provided by the Management Development Group (MDG), based in Edinburgh. These are being modified to become multi-disciplinary courses, as an external evaluation report indicated this would be more effective. It is widely recognised by senior registrars that there will be questions about their management experience at the time they come for interview for consultant appointments, and therefore there is an increasing pressure for these individuals to have completed some management training by this point in their career.

Consultants

Consultants have the national series of residential and also non-residential courses provided by the Management Education for Clinicians (MEC) initiative. These have two main aims: primarily, awareness of both health service structures and changes, and also an awareness about personal skill development, which can then be expanded in other courses provided by MEC. The usual management skills are all catered for. The wide range of programmes provide a natural progression from awareness through to skill development, and these consultants may then go on to take part in other activities as indicated below.

Clinical directors

Clinical directors have in many cases gone through basic management training (as indicated above) but, in addition, some have had special, within-hospital development using management consultants and, in some cases, MEC. They have also been encouraged in the last three years by MDG to attend extensive two-to-four week residential courses, mostly in England, to develop some of their skills. This has been refocused, with a similar programme being provided by Strathclyde University within Scotland. There is a need to define the training needs of individuals, and the training and development of the clinical directors and their teams.

Medical directors

For medical directors as a group there is a national programme for their own development with regular meetings and learning sets. Many have only been recently appointed and future training needs will be developed, as needed, by MDG.

Other doctors

There is a special group of doctors with occupational health responsibilities. Courses are organised through the Department of Public Health at Glasgow University, with a remit for the whole of the United Kingdom – Management Education for Occupational Health Practitioners (MEOHP). Unlike the courses for hospital consultants, these are all multi-disciplinary – involving both doctors, nurses, occupational hygienists, and health and safety advisers. They have a particularly useful group dynamic arising from the contrast between occupational health doctors working in the public sector and those, the majority, working in the private sector.

Most of the developments indicated above are aimed at hospital doctors and are mostly to do with personal development rather than organisational development. However, there is a programme of organisational development being put in place by MDG and by other providers. Increasingly, the independence of trusts means they are looking for their own in-house training arrangements, and these are being provided in a number of ways, usually focused on a trust's special requirements. It has to be said that there is no one 'solution' for training needs, and there is evidence of a great deal of exploration on the part of personnel directors in the designing of unit programmes with the providers.

In general, national programmes tend to be uni-disciplinary, with one exception: in the development of the MEC programme, careful provision has been made for a multi-disciplinary element to training. Some units designing their own organisational development have also initiated multi-disciplinary training for clinical directors, and their relevant business and/or service managers. These units usually see a need for team development at the current stage of their development either as, or towards, trust status.

In general practice the provision is patchy, but because of the financial incentive for general practitioners to attend courses, attendance

has been quite good. On the other hand, the fees payable by general practitioners for these kinds of courses are low, compared with the normal fees expected of the high standard of courses aimed at consultants and senior registrars. Discussions are under way to find ways of dealing with this problem, including one side-effect which is to make joint courses involving both hospital or community-based consultants together with general practitioners difficult to set up.

The provision of management training is done in a variety of ways – from a few lectures and small-group sessions with undergraduates, through to non-residential half-day and residential two-to-six-day courses for hospital consultants, occasionally even longer courses for some of the clinical directors and medical executives. There seems a clear preference in terms of doctors' perceptions, and also effectiveness, of courses for small-group teaching done in depth, rather than short, scattered lecture presentations. The strength of group development is the amount of sharing that goes on across hospital boards and specialties. This is also seen with general practitioners who have a different variety of experience to bring to a group. This cross-fertilisation strength is much less obvious in courses held within units, since most consultants know each other fairly well. Some doctors in Scotland have independently done MBA degrees, but these have usually been financed by themselves rather than their employing authorities.

The training is usually organised by the purchasers of training, mainly MDG, MEC and trusts. For general practitioners, it is the postgraduate organisations in various parts of Scotland. Often the same business consultants and/or academics are used, although to provide the programme put on by MEC there are some 140 different lecturers available for different parts of the twenty or so modules available. The large numbers disguise the necessity to have several teams who can provide similar sessions because of the frequency of courses, and also disguise the existence of a 'core' group of teachers who work closely with the two directors (Drs Robin Knill-Jones and Sheena Parker).

The MDG programme for senior registrars and the MEC programme for consultants have been independently evaluated by a mixture of discussions with doctors on the courses, teachers of the courses and employers of the doctors. This has helped identify the way forward has been a useful part of the development of the whole Scottish programme of management development. Routine evaluation of each course is always done to feed back performance to the teachers/trainers. Annual

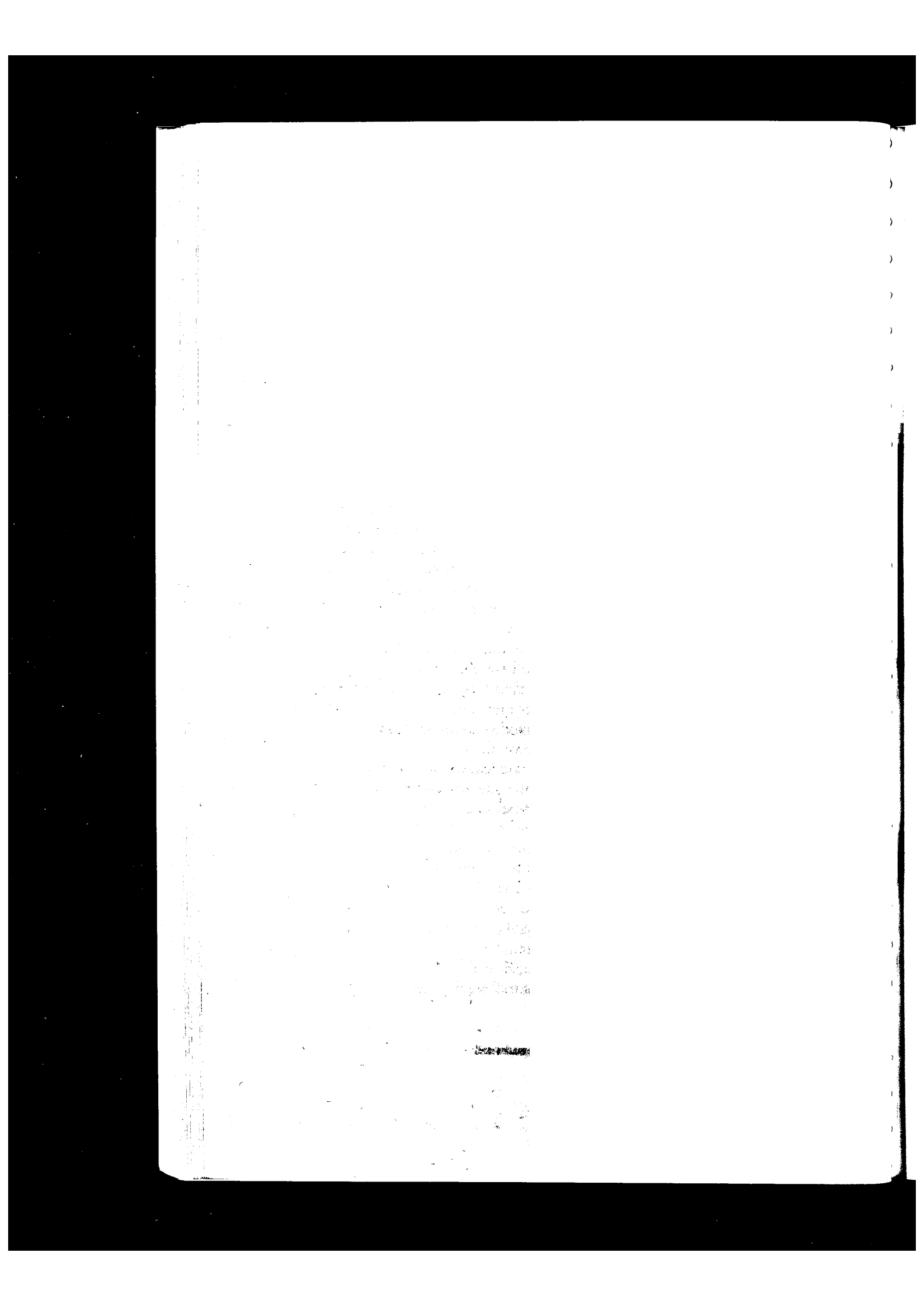
review also allows the examination of the proportion of consultants by health board and specialty who have attended the courses, currently about 26 per cent of all the 2,400 consultants in Scotland. An independent evaluation has not however been undertaken in management training courses for general practitioners.

THE FUTURE

The two principal organisers and facilitators of management training for doctors in Scotland are MEC, under the postgraduate medicine organisation, and MDG which has a remit for training for all employees in the NHS in Scotland. The directors meet regularly and provide a reasonably integrated approach of management training for doctors.

The key element here is the provision of a variety of courses to meet the changing needs of doctors employed in the health service and by other organisations. It is useful to have several providers and a variety of course styles, together with the in-house training indicated as being important, at least at this stage for trusts, for supporting their own individual organisational development and teamwork, and also for other local reasons.

More attention needs to be given to long-term development of doctors who seriously want to take on full-time management. However, it does seem that individuals who have made this choice in their career development have not been inhibited by any apparent lack of assistance in making the transfer. Missing in Scotland is an organisation such as the King's Fund College in London which provides both experienced course teachers and facilitators, and also academic leadership. This is being remedied in Scotland by setting up a joint unit with a similar remit by a co-operative venture between the Universities of Aberdeen and Strathclyde.



Spain

INTRODUCTION

Although the Spanish debate in the 1980s mainly focused on major health system reforms, recently there has been an increasing concern with the role of doctors in the management of resources. It is not an easy task to analyse this process in depth. First, because of different health care networks; second, because of the devolution process towards regional authorities (begun in 1981), which allows those regions (involving half of the country's population) to formulate and develop different health care policies.

Nevertheless, we can simplify our study focusing on INSALUD (Instituto Nacional de la Salud – National Institute of Health), which is the health care network of the social security system, within the National Health Ministry, considering that this institution is the most important both for the size (42 per cent of the population) and for the influence in health care policies of public networks and organisations.

As long as Spanish hospitals and ambulatory services have medical managers, it is easy to understand that management development for doctors can be understood as having a two-fold function:

- improving the management training for doctors currently involved in management (as general managers or medical directors);
- providing management knowledge and skills to physicians in order to introduce better resource management in clinical units.

The first aspect attracts more attention from policy-makers. In recent history – 1960s and 1970s – within the social security's hospital network, it was usual for some doctors (medical inspectors) enrolled as civil servants to administer hospitals. In the 1980s, clinicians were appointed to management positions in hospitals, which most of them abandoned after a short term (2–3 years), and only a selected group 'survived' during the decade. Therefore, the turnover of physicians in management jobs has been very significant, creating an additional workload for management training: whenever a round of basic training was completed, another one had to be started for the new managers replacing the previous ones.

The experience with the introduction of managers in Spanish public hospitals reveals that being a manager is not a sufficient condition for management. The administrative incentives, tools and environment

for doing real management, and the involvement of doctors (specially those who are responsible for the hospital's units) are important issues for a successful hospital policy. Therefore, a new commitment to the goal of training physicians for better unit management is expanding throughout public networks. This trend is also manifested in the increasing offer of management courses provided by the National School of Public Health and business administration schools. Notwithstanding this new commitment, an overall governmental policy addressing specific goals has not been formulated yet.

THE CONTEXT OF MANAGEMENT DEVELOPMENT FOR DOCTORS

The big issues

Many factors influencing the involvement of doctors in the management of resources can be mentioned: economic and political factors, management models, etc. But it can be said that the failure of the mechanistic and authoritarian management models of the 1980s to understand the health sector and the role of the professionals, is a major reason for the new interest in the clinical units and the basic level of medical practice.

The improvement of management performance of doctors, both at the hospital's micro-level (clinical units), and at the macro-level (hospital overall management), are closely intertwined. In fact, one of the natural paths for doctors to achieve higher-level hospital management positions could be through a successful experience as unit or department medical chief.

From the Spanish point of view, at least three big issues must be considered for the success of the involvement of doctors in management:

- building up an appropriate management framework which can attract and progressively motivate doctors to participate in resource management activities;
- counterbalancing the attitudes against hospital management, perceived by doctors mainly as a cost-containment exercise, threatening their professional autonomy and freedom;

- providing the tools (knowledge and skills) for doing better management both at the micro- and at the macro-levels.

It is very difficult for a doctor to get involved in management activities in a centralised structure in which little room is left for hospital decision-making, and even less for the responsibility of clinical units. Therefore, it is necessary to create or improve a management framework, based upon the relationship between the inputs (mainly financing and allocating of resources) and the outputs (previously agreed levels of activity), both at the overall level of the hospital and at the clinical unit level.

Regarding the negative attitudes of doctors against management, it is very important to promote a shift in hospital policy; some of the components of this new policy could be: a new concern for the quality of care, a stronger commitment to the improvement of the hospital service, and a better understanding of the difficulties implied by the dilemma of rationing health care. A further dimension must be considered for structuring the teams of doctors within management principles: the teams themselves. Spanish hospital doctors are organised in a hierarchical structure based upon medical specialties. But the role of the heads of the clinical units or departments has created a very particular leadership style combining authoritarianism and *laissez-faire*.[1]

Finally, sometimes the attitudes (apart from the interests and values) are heavily loaded by misunderstandings created by the lack of knowledge. Training, used as a marketing strategy can counterbalance, partially at least, the normal difficulties. In fact, sometimes involvement in management has become for the newcomers a magic medicine against two of the worst diseases of clinical practice: boredom and routine.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

Career paths for doctors in clinical management

As we have mentioned, hospital managers are almost entirely physicians, both in the public and private sectors. It is interesting to review the management structure at the macro- and micro-levels of the hospital.

The usual formal management structure in Spanish hospitals, at least in the public sector, is as follows:

- a general manager (*director-gerente*), at the top of the organisation, appointed by the central or regional health authority, and accountable both to the provincial and national (or regional) bodies responsible for hospitals;
- in big hospitals, it is possible to find a deputy-general manager, or some position like health care director, who manages the overall co-ordination of health care policies and services in the hospital;
- the second step in the hierarchy is usually the 'triumvirate' composed by the medical director, the nurse director, and the administrative director;
- apart from the line structure described above, it is possible to find a wide range of staff in the areas of information systems, information technology, quality assurance, patients marketing, clinical records, patients' admission, etc. It is difficult to describe a general pattern, because of the variation between different hospitals, even within the same network.

All the above jobs are commonly identified as elements of the non-clinical career, and do not have professional legitimacy. In fact, doctors enrolled in those jobs are frequently deemed as frustrated clinicians or vocational politicians.

At the micro-level of the clinical unit, there is a clinical hierarchy:

- resident physicians – trainee doctors who are not really part of the hospital staff, although most of the day-to-day work is under their responsibility;
- *adjuntos* – the basic grade of fully qualified medical staff;
- *jefes de sección* – responsible for a clinical unit within one of the nearly 50 medical specialties;
- *jefes de servicio* – head of hospital specialty services, at the top of the medical staff of a specialty service in the hospital.

The basic characteristic of the pyramid of hospital physicians is the hierarchical structure within the professional level, at least formally, which exerts a major influence in the culture and behaviour of doctors.

In primary health care (PHC), a new structure, named 'PHC Teams' and covering half of the country's population, is directed by a PHC manager at the district level, and organised with a co-ordinator of the team, usually elected by the team and rotated, who combines

management of the team and centre with the health care of his/her own list of patients. The payment system in PHC, based on a mix of salary and capitation, and the community health motivation of most of those young doctors and teams, make real teamwork feasible, in contrast with the authoritarian and hierarchical organisation of physicians at hospital level. This hierarchical structure of doctors in hospitals concentrates the legitimacy and power of the hospital physicians, and generates a basic network to be taken into account in the daily bargaining of hospital management.

As we mentioned above, there is a split between doctors in the management career path and those in the clinical one. One of the main objectives of the current policy is to reduce the antagonism between those two groups, and promote a smooth and co-operative relationship. Another objective to be mentioned (1985 regulations) was that appointments for heads of clinical departments and units should be based on the clinical management knowledge, skills and experience of the applicants, and that those doctors could be maintained or dismissed according to the performance of their units.

In Spain, there is not a medical managerial career as such. The main public hospital network (social security), had (in the 1960s and 1970s) a group of civil servants called 'medical inspectors', who covered most of the management task of the hospitals, as well as the evaluation and control within the social security network. Presently, some of the Medical Inspectors continue in management jobs, although it cannot be considered as a professional career, since many other groups can enter into management activities, and in fact quite few actual managers are medical inspectors. In the case of clinicians, who in the 1980s became the prevalent source of hospital managers, there is also a lack of professional career and, as we mentioned earlier, the turnover has been very high in the past years.

Most management contracts are called 'top management contracts', which is different from the conventional labour regulations, allowing substantial improvements in salaries and performance-related awards, as well as the tailoring of contracting conditions. Nevertheless, the lack of security in the continuity of the contracts (most have to be renewed every four years), might offset the initial salary rise.

One of the common opinions (from a survey conducted in 1993) is that the main incentive for clinicians to get involved in management is the lack of promotion in their own clinical careers. Alternatively, the

weaknesses of the 'quasi-career' in management lead clinical doctors to have always in mind the possibility of going back to clinical activity.

There needs to be an open approach that involves doctors from all backgrounds in management, and retains the best of them in a management career that is stable.

Doctors as managers of clinical units

In February 1985 some shifts in the legal regulations of the social security network of hospitals took place, aimed at introducing management responsibilities in the job description of the heads of specialty services and sections, offering for the first time the opportunity to dismiss poor performers. In fact, even though the formal appointment of those heads of specialty services involves some management training requirements, and a project for organising and improving the specialty unit, the real situation has changed very little. First, because most of the existing heads of clinical services were already appointed in the 1970s (and the new laws do not allow them to be removed), and second, because in the absence of an alternative professional career where clinical or research promotion can be implemented, the medical unit management positions are the only ones that can involve merit promotion for the best medical professionals.

One of the current debates is the creation of a 'professional medical career'; this is an especially important issue for hospital doctors, if we consider that most of the staff (in the three stages of the current clinical structure) have a narrow range of ages, and the possibilities of promotion are severely weakened due to both the unbalanced retirement process, and the limited number of head-of-unit positions (which, in the end, must be justified through organisational arguments).

Doctors and management development

In 1991, a Parliamentary Commission for the analysis and evaluation of the Spanish NHS stressed the lack of awareness on the doctors' part about their role as real 'managers' of the public resources under their responsibility. Different proposals were formulated which included the improvement of training (even at undergraduate level), and the creation of economic incentives for rewarding the efficient and effective utilisation of resources.

In fact, in spite of the failures of some policies like productivity payment in the late 1980s, or some shortcomings like in the introduction of managerial duties in the heads of clinical units, the environmental pressures have finally introduced among clinicians the idea of improving the use of resources and the growing pressure towards increasing the accountability of those activities financed through public money.

In addition, some parts of the medical profession are able, through literature and international contacts, to import those 'environmental' conditions from other countries, applying them to their local situation. Those doctors, usually at the 'professional vanguard', have frequently considered the advantages in the reduction of uncertainty obtained from leading the process themselves, rather than being passive in an externally controlled system.

WHO ARE THE MAJOR TRAINING PROVIDERS?

The paucity of the data available does not allow us to make an inventory of institutions providing training in management for doctors. Nevertheless, the most important sources of training can be classified as follows:

- schools of public health, either belonging to the national government (Escuela Nacional de Sanidad/ National School of Public Health), or (totally or partially) to some regional governments like in Andalusia, Madrid, Valencia and Barcelona;
- business administration schools, private institutions with their headquarters in Barcelona and Madrid like EADA (Escuela de Alta Dirección y Administración de Empresas), ESADE (Escuela Superior de Dirección y Administración de Empresas), ICADE (Instituto Universitario de Administración y Dirección de Empresas) and IESE (Instituto de Estudios Superiores de la Empresa). Most of them have hospital management courses within a wide range of MBAs and short courses;
- there are other institutions progressively interested, and especially some universities, although the general level of involvement of Spanish academic institutions in this field is very scarce.

ARE TRAINING PROGRAMMES EFFECTIVE?

We cannot really answer the question about the effectiveness of the training methods for doctors, considering the lack of experience in Spain. Notwithstanding this, we can identify an evolving trend in the supply (and demand) side of training programmes and methods.

Short-term courses tailored to meet the particular needs of managers, medical directors and medical heads of hospital specialty services are currently being developed, as well as on-the-job training seminars meeting the specific requirements of doctors who want to progress in their management careers.

The availability and accessibility of a wide range of training activities are likely to be positive determinants for improving management development. They are also important for bridging the existing gap between clinicians (without any management training), and doctors in management (which is where the main training investment of the system is concentrated). The latter can be used as a means of restoring and facilitating the relationship between managers and clinicians.

The methodology of training is also important. An academic approach might not be as effective as practical case studies, fieldwork or applied training within the framework of the existing problems at units or hospitals.

THE FUTURE

Three different approaches are likely to influence management development of doctors in Spain:

- sensitising physicians for active involvement in resource management;
- introducing environmental change to promote management development;
- implementing a well-designed training strategy addressing mid- and long-term goals.

Sensitising doctors

This is an important topic in the Spanish debate. It is apparent that doctors are increasingly concerned with managerial issues. Real economic problems are the most effective school for sensitising doctors. But in fact, there are no implemented mechanisms for the introduction of managerial tools and elements in the daily functioning of the hospital units.

Most central and regional government projects address the 'management by objectives' strategy for hospitals and their units; nonetheless, the real incentives for shifting the behaviour of physicians must be designed and experimented in practice. The productivity incentive scheme implemented in the late 1980s has provided no evidence of greater doctor's involvement, yet it has created some negative side-effects in their morale.

Although training strategies are considered to be important (and the increasing demand for courses is a direct demonstration of this), the main constraints in sensitising doctors, and involving them in management issues, seem to be the existing structure and incentives.

Environmental changes

Some new policies are about to be implemented aiming to produce environmental changes focused on efficiency.

- First, the formalisation of contracts between INSALUD central authorities and public hospitals, tends to create an explicit flow and balance of economic resources and services available.
- Second, the modification of the contractual arrangements of doctors through the 'co-operative agreement', provides local managers with a new tool for negotiating with the heads of department and clinical units (and, through them, with individual physicians), based on 'management by objectives' procedures, and including financial rewards for good performance.
- Third, a new scheme for controlling the spread of emergent technology and evaluating the existing ones, is envisaged. The creation of a technology assessment agency is also under consideration. Similarly, new emphasis on protocols and guidelines would exert pressure on the previous autonomy of doctors,

promoting a new awareness of quality and cost, as well as an increasing accountability for public resources.

Training strategy for management development

The increasing activity of training medical heads of department and units in management, is to be expanded and improved in the next years, considering policy priorities and physicians' new demands for training.

A short-term training strategy must focus on new ways of adapting managerial theory and methods to the specific demands and needs of the clinical level. The utilisation of case studies and problem-solving methods, as well as limiting a purely academic style, could be elements to consider. The optimum would be the utilisation of those training methods to which physicians are accustomed, or that are nearer to their background and daily experience.

Nevertheless, a mid-to-long-term strategy must be built up addressing the following problems:

- weaknesses of general management theory as applied to professional scenarios and clinical settings;
- relationship between health care policies and clinical management models: the ongoing reforms are the real environment which will in the end determine the micro-level policy, and therefore the selection of the methodological approaches to be implemented;
- considering the long term, major changes of professional values are required for a real and stable change in the role of doctors, for broadening the individual ('my patient') approach, with a new set of societal considerations. Within those new elements to be taken into account, ethics and management of resources are important ones.

A balanced combination of structural changes, incentive adjustments and training approaches must be at the foundations of a renewed hospital policy in Spain, which can successfully address the involvement of doctors both at the micro- and macro-levels, in order to secure their important contribution to the improvement of the management of health care resources.

Sweden

INTRODUCTION

Sweden is divided into three political and administrative levels – national government, county councils and local municipalities. All levels of government are represented by directly elected politicians and levy taxes to finance their activities. Each level has extensive functions in the social welfare system. There are 23 county council areas and three municipalities with county status. The populations of these 26 units range from some 60,000 to 1.7m inhabitants (about 300,000 on average). Close to 90 per cent of the Swedish health care expenditure was publicly financed in 1991. The responsibility for provision and financing of health care lies with the county councils.

According to the Health and Medical Services Act, county councils are required to promote the health of residents in their areas. They are also responsible to offer all their inhabitants equal access to good medical care. The Act requires county councils to plan the organisation of health care with reference to the aggregate needs of the county population.

In 1989, the number of physicians in Sweden was 25,000 (about one doctor per 340 inhabitants). Most Swedish physicians are salaried employees of the county councils and the majority of them work in hospitals. The proportion of physicians in primary care is small compared with most other OECD countries. Physicians work either in hospitals or in primary care. Hospital physicians are usually involved in both in-patient and out-patient services.

Structural changes in health care are on the political agenda in Sweden today. Several reviews on the present system and options for change have been published and reform initiatives are being implemented. One of the main themes is a separation of the financing and providing functions of health care to increase productivity by competition. Another issue suggesting changes is the demand for consumer choice within health care.

In the traditional financing model, resources for health care within a county council are allocated to hospitals and health care centres through a complex budget negotiation process. Budgets cover a one-year period and historical costs are a major determinant of future budgets. There is normally no direct connection between the actual production and the amount of resources available at unit level. In the traditional system, cost control is achieved through fixed budgets and not through cost accounting.

The hospital department is a strong and rather independent organisational level in Swedish hospitals. Budgets are allocated to this level and hospital beds belong to individual clinical departments. An in-patient is administratively discharged from the hospital department and not from the hospital as in most other OECD countries.

From a functional perspective, a hospital could be divided into three different kind of units (departments): clinical departments (e.g. general surgery), medical service departments (e.g. diagnostic radiology) and general service departments (e.g. catering services).

By tradition, each department in a Swedish hospital has its own budget. This structure creates a weak connection between authority and accountability when it comes to resources. A radiology investigation ordered for a patient in the department of surgery will be a cost within the budget of the department of diagnostic radiology. It has been estimated that for some hospitals only about half of the costs generated by the decisions of a surgeon will consume resources within the budget of their own clinical department.

A general tendency is therefore to create *internal markets within hospitals*. There should be no 'free utilities' available to physicians. In this new situation, service departments are financed by an income instead of a fixed budget. The income is generated by selling services to other departments. The clinical departments may still be financed by fixed budgets in this model. However, when this is the case, the traditional budget of a clinical department will be expanded to include estimated costs for all hospital services needed by the patients in the unit. According to a recent survey, 25 out of 26 county councils had at least one service unit financed mainly by selling services.

Many county councils have implemented more profound changes in the organisation of health care. The general principles behind changes have much in common. The trend to make a division between purchasers and providers has continued to evolve in many county councils. Financial agreements for clinical departments vary from block contracts to per-case reimbursement and fee-for-service arrangements. Per-case payment based on DRGs was used (to at least some extent) to finance hospitals in seven county councils in 1992.

THE CONTEXT FOR MANAGEMENT DEVELOPMENT OF DOCTORS

The big issues

In Sweden, it is generally accepted that doctors should assume greater responsibility and become more involved in management. This is seen as one way to increase the efficiency of the health care system. Doctors – at any point in their careers – are managers of clinical resources. How resources – human and financial – are used will, to a very large extent, be determined by doctors. Medical decision-making at unit level will therefore be of critical importance when it comes to controlling costs and improving efficiency.

Every doctor should be able to master also the administrative side of the medical position. To achieve this, knowledge outside the sphere of 'pure' medicine is necessary, so that medical problems are perceived in their context. A doctor has to take into account how decisions taken will affect other patients, but also other professionals, different units within the health care system and institutions outside that system (e.g. in the social security system).

Encouraging doctors to view their role in a wider perspective implies a change in the culture of health care as an organisation and a change of attitudes. In Sweden, this change has occurred during the last 5–10 years. Most physicians have now accepted that involvement in management is part of their role and there is a growing awareness that a new and important dimension has been added to the medical profession.

Many initiatives and reforms that are currently being implemented in Sweden are aimed at using resources more efficiently. With limits on funding, it is necessary to increase efficiency, to meet the demands from an ageing population and at the same time, make possible the introduction of new medical technology. The process of changing health care thus depends very much on being successful in bringing together economic, organisational and medical perspectives. Physicians in leading positions, as well as other managers, may be regarded as key agents of change. Doctors in such positions may play an important role in influencing the behaviour/decisions of their colleagues, if there is a clear management structure and the doctor in charge has management authority. Following new legislation (see page 170) such conditions now exist in Sweden.

Without the support and commitment of key personnel, such as doctors, it is difficult/impossible to improve the delivery of health care. It is therefore essential to appoint doctors as managers (e.g. clinical directors) and to prepare them for their role. Efforts in this area have been under way since the early 1970s. Recent developments (e.g. decentralisation and new financing system) have underlined the importance of adequate training programmes, and have led to a number of initiatives concerning management development for doctors.

Barriers to success

Although there has been an increasing interest in management issues among Swedish physicians during the last few years, some barriers to success in this field still exist. Most doctors practising medicine today have been used to a health care system in continuous expansion. During this period, economical issues did not receive much attention from the profession. It was more a question of how to distribute new resources available for health care. Today, the period of fast expansion is over and an efficient use of resources is an important aspect of clinical medicine. However, it will take some time for health care professionals to adjust to this new situation.

One barrier to involving physicians in management is related to the fact that most physicians have chosen their profession in order to work with individual patients. Even if management issues may be interesting, many doctors find it difficult to lose their daily contact with patients. Much of the traditional professional prestige is also connected to the expert knowledge in this field of medicine. Another factor which has to be considered is what could be called the 'exhaustion syndrome' – that is, to have a strong work pressure and keep working in an 'uneconomic way', without ever taking the time to analyse the individual working pattern, to be able to 'release' time.

It is also true to say that there is a very strong value within the profession placed on being 'overworked'. Medicine is a 'difficult' and very demanding job. As a young doctor, you should have at least as hard a time as the older generation had. In this way, bad working habits and not optimal attitudes are transmitted from one generation to the next.

Tradition, obviously, is important – just look at how difficult it is to change patterns of medical practice.

FACTORS FOR SUCCESS

Some factors, however, are facilitating the interest in clinical management among physicians. There is an awareness in the medical profession today about the general economic situation. It is to an increasing extent accepted that an efficient use of resources will reduce the need to make priorities between patient groups and treatment programmes.

Health care of today is characterised by the need for close co-operation between different groups of professionals (doctors, nurses, physiotherapists, etc.). It is important to recognise this situation when discussing management issues. In a professional organisation, it is not enough to have the formal managerial authority from higher administrative levels. In order to develop successful leadership, the manager must also find acceptance among various professions involved in the organisation. This does not imply that a clinical manager should have superior expert knowledge of diagnosing and treating patients; however, it is crucial for success to have an understanding of the culture and professional values in the organisation. Clinicians and administrators have developed different 'cultures' in Swedish health care. One important factor for success in clinical management is to reduce barriers between these two groups in the organisation.

Educational activities at all levels will further increase the knowledge of the present economic situation in health care and the consequences for patients if the limited resources available are not carefully managed. Management training can also provide doctors with the tools necessary for a better utilisation of clinical resources.

A general programme on how to promote doctors' interest and skills in management was launched in Sweden in the early 1980s. The programme focused on:

- an early sensitisation to management issues – already in the undergraduate curriculum;
- a continuation of management training throughout the whole medical career. Relevant elements and forms of management training should be available at each stage of a physician's career. There should be a mix of theory and practice.

Of particular interest was that the major actors in Swedish health care could gather around a quite detailed programme outlining these ideas. The programme was published in 1982, and is available in an English version. ('Continuous Administrative Training for Physicians – Educational needs and structures'. The Federation of County Councils, Stockholm.) This programme tries to address some of the major obstacles for doctors to move into the management area. Among these are the following.

Traditional values within the medical profession

Since the profession of medicine is so closely linked to handling individual patients and their problems, administrative tasks are in a way very abstract for a regularly trained doctor. In administration you have to think in terms of groups of patients, population, etc.: the individual perspective is transformed into a group perspective. This is a very important shift, which has to be developed both through individual experience and good management training. Of great importance is what kind of attitudes older doctors – role models – convey to younger doctors. This is a key mechanism for developing relevant management skills and attitudes among doctors. Medicine as a profession is taught and learnt to a great extent by the role models. Sadly enough, a lot of the bad role models regarding administrative tasks are still present.

Among the traditional values that hinder doctors to move into administrative work is also the feeling that you have to *work with patients all your available time*. For many doctors, time spent without direct patient contact is regarded as less valuable time. Self-esteem is generally to a great extent linked to direct patient activities. This is very much a psychological problem since today, in reality, medicine is very much groupwork, where a lot of different skilled personnel are working with the patients together with doctors. To a great extent, doctors – also in ordinary clinical practice – are working indirectly with patients. The step into administration is not very far – it means concentrating mainly on indirect patient work, supervision, planning, control, etc. From a psychological point of view, though, it could be a big step. Doctors seem generally to be afraid of losing their identity if they 'leave' their patients. These issues have not yet been fully regarded when planning and performing management training, supervision activities, etc.

The importance of 'role models' should not be underestimated. If you see a strong and confident doctor 'leave' his or her patients to perform administrative tasks, it can have an influence on the decision – at some stage of your career – to take the same step. Our experience in administrative training for doctors is that good role models are of vital importance. This also helps to explain why management training for doctors preferably should be performed close to the medical setting.

THE ETHICAL PERSPECTIVE

The ethical perspective embedded in clinical medicine is also of importance. The Hippocratic oath tells the doctor to do 'everything possible for the patient in front of him/her, regardless of resource consumption'. Everything else is unethical and bad medicine. The shift from individual to group perspective places an 'ethical burden' on the doctor that relates very much to the core values of the profession. The conflict between economics and ethics is rapidly moving into everyday medicine through new financing mechanisms, selling–buying concepts and the inevitable pricetags in the clinical setting. These conflicts will form a major part of tomorrow's clinical world. Each doctor has to handle them, but for leaders of clinics this will generate certain tensions and difficulties. The conflicts are inevitable: resources are constrained, while demand for health services continues to grow, and priorities have to be set on all levels of the health care system. In the clinical setting the most important trade-offs have to be made. This is a major reason why doctors should assume a management role in the clinical setting. In order to be able to make good decisions regarding resource constraints, in practice, medical knowledge needs to be combined with economic/administrative skills.

THE CONTINUUM OF DOCTORS AND MANAGEMENT DEVELOPMENT

Basic undergraduate medical education takes five and a half years. Graduation from medical school is followed by a 21-month internship, which is a salaried appointment with one of the county councils. After this period of general training, the doctor is registered and licensed to practice.

The next step in the career of a junior doctor is specialist training. The general arrangements for specialist training have been reformed and new regulations from the Department of Health came into effect on 1 January 1992. According to these new regulations, the minimum time to be spent in training to qualify for a specialist certificate is five years. This applies to all specialties – at present 60. (In Sweden general medicine is a specialty, which means that physicians working in primary care are regarded as specialists.)

The requirements concerning the content of training in each specialty are regulated by the National Board of Health and Welfare, the government agency which supervises postgraduate medical education, and grants licences and certificates. These regulations, however, are not detailed and merely specify goals in terms of knowledge, skills and attitudes that are considered necessary for a doctor to be recognised as a specialist.

A young doctor, having obtained a licence to practise, will have to apply for an appointment in the chosen specialty with a county council or any other employer willing to take on non-specialists and arrange for their training. Since 1992, however, there have been no special training posts held for a limited number of years. All doctors who are licensed, are supposed to have permanent appointments, except at teaching hospitals/departments.

There used to be clearly defined – in legislation and labour contracts – different positions for specialists in hospital, with the grades 'ward physician', 'assistant consultant' and 'consultant'. With changes in legislation (see below), there is no ground for a meaningful distinction between these categories, and the current development is that county councils have chosen (or are contemplating) a simpler career structure with only two steps – ward physician/specialist physician and consultant. (In primary care, the position for specialists still in use is 'district physician'.)

The Health and Medical Services Act, which came into effect in 1983, defined the role of consultants and district physicians as having 'medical management responsibility'. This meant that they were in charge of diagnosis, care and treatment of the individual patient and had the clinical freedom to practise in the way they considered appropriate. In each department/specialty there was however a designated clinic chief, usually one of the senior doctors. The responsibility of the clinic chief was to deal with matters concerning administration, i.e. decisions on

economy, organisation and personnel of the department. In primary care, there were similar arrangements, with one of the district physicians assuming responsibilities similar to those of the clinic chief. (With regard to management structure and management style, it should perhaps be mentioned that in Sweden there have never been 'consensus management teams' of the type found in some other countries.)

During the 1980s, there was a growing interest in managing clinical activity more effectively. The situation whereby medical leadership was split among several people (the consultants), and division was made between medical management and more general management, was no longer considered feasible. The increasing tendency towards decentralisation, where departments (and health centres) were to assume more responsibility, called for a more efficient management of clinical resources. It was felt that management of clinical activities – as of other activities – should be the responsibility of *one* person.

The Swedish Parliament found it necessary to make changes in the Health and Medical Services Act, which came into force on1 July 1991. This new legislation states that in a health care unit a designated 'chief consultant' should have an overall responsibility for running the unit, i.e. should provide medical leadership as well as leadership in matters concerning administration, and be accountable to the county council. The county councils have the right to decide which units must have a physician as head. The county councils have appointed chief consultants in clinical departments, medical service units, and health centres, with some exceptions due to local conditions or policies.

The new provisions in the Health and Medical Services Act have meant that the number of doctors having management responsibilities as an effect of legislation has diminished from some 8,000 (all consultants and district physicians) to about 2,000, i.e. the chief consultants. Chief consultants are appointed on a fixed-term basis, the normal term of office being three years. The salary is set for each individual by the county councils and preliminary figures show that the salary of a chief consultant is about 25 per cent above that of a consultant.

Apart from the chief consultants there are no specific roles, i.e. no special positions, for doctors who take on management responsibilities. It is considered normal for any doctor – or other staff – to be engaged in management from time to time or more permanently. The chief consultant may, and is indeed expected to, delegate responsibility and tasks to other physicians, head nurses, etc.

Training in medical school

General knowledge and skills necessary for all doctors in order to function in junior positions must be acquired during the basic training. The content of training is defined nationally. Most of the goals, for obvious reasons, are related to the development of knowledge and skills in clinical medicine. However, it is also clearly stated that the student must have basic knowledge concerning health economics and organisation of health care. The student should develop skills which prepare him or her for teamwork and co-operation with the different groups of personnel in the health care sector.

It is important that the student gains an insight into the economical consequences related to different procedures in medicine and has a general understanding of the relevant administrative routines. These perspectives are integrated into periods of practical training in different clinical departments.

The more general aspects related to administrative medicine are mostly a part of the curriculum in social medicine. The organisation and the economics of the health care sector are subjects taught at this level. General principles of health economics are often integrated into this curriculum. The student should also be familiar with legislation concerning the health care sector. More practical skills are how to prepare a certificate of illness and to co-operate with the local health insurance office. Currently, the aim is to run at least a one-week course in the undergraduate curriculum around these aspects.

Internship

During internship, after graduating from medical school, the junior doctor will work under close guidance by experienced colleagues. The areas of training are nationally defined and include: internal medicine, surgery, psychiatry and general practice.

Guidelines for internship have recently been published by the Swedish National Board of Health and Welfare (NBHW), the government agency supervising postgraduate medical education and all medical personnel. The focus is on diagnosis and treatment of individual patients. However, it is also important at this level of training to develop a basic understanding of administration and management. The goals specified in this field are:

- proficiency in managing health care in a smaller team (group);
- knowledge of the organisation of health care and its role in society; administrative routines such as preparing budgets and schedules; health economics, e. g. costs for drugs, surgical procedures, laboratory tests, diagnostic radiology;
- to be skilled in participating in continuing education of health care personnel; inspiring personnel and creating a teamwork atmosphere.

The acquisition of these skills and knowledge should be an integrated part of clinical work and training. A general perspective on the issues is facilitated by the fact that the intern is exposed to several important areas of medicine.

Specialist training

Internship gives a general experience in the main specialty areas of clinical medicine. After this period, the physician specialises in a more defined area of medicine. The resident will work under guidance by a personal tutor in the chosen specialty and related ones. Training of a more formal character (courses etc.) is also included in the residency period.

The goals to be achieved during the specialist training are also defined by NBHW. One of the stipulations is that all specialists must acquire skills and knowledge in administration, management and health economics. The most important route to these skills is through the guided work in clinical medicine. However, it is essential to have a more formal training as a complement to the clinical experiences. One-week courses in administrative medicine have been available since the middle of the 1980s. Such courses are organised by university departments of community medicine, other university departments, clinical departments, county councils, and also by some consultancy firms. The courses are of a general character to suit residents, regardless of their fields of specialisation. Typical topics covered are changes in health care organisation, health economics, management at hospital/departmental level and more general leadership issues. These courses have, by tradition, been aimed at residents with a special interest in management. The capacity is now expanded and there are plans in some county councils to make such courses available to all residents.

Management training for doctors should form a continuum through the medical career, and it should have a proper balance of theory and practice. Role models are useful at all stages. It could be argued that undergraduate training should have a focus on practical, very concrete skills. Medical students astonishingly do not seem to be very interested in theory regarding health economics and related areas. But they want to understand how the health care system works, who has the power, how key decisions regarding resources are taken.

In the internship and residency periods, on-the-job training is very important. Young doctors should get smaller administrative tasks to perform. This could mean planning rotation work schemes for doctors and/or other personnel. It could also mean starting smaller evaluation projects within the framework of the clinic, analysing patient flows, looking at resource consumption patterns, etc. This form of management training is of great importance, but in fact very seldom at hand, according to our experience.

Specialists/senior doctors

After the residency period, follows the career stage where some doctors start to specialise in administrative tasks. Of great importance is a spectrum of management training options. In Sweden more systematic efforts have been made since the later part of the 1970s to develop training programmes. The Federation of County Councils and the medical profession have had a common interest to launch different types of nationally organised programmes, often followed by local county council produced programmes. Three more distinct stages in this development could be distinguished.

- The first phase during the late 1970s and early 1980s consisted of nationally produced three-week courses (one week at a time with intervals), focusing on knowledge about the system, actor perspectives, health economics and some evaluation skills. Psychological leadership perspectives, including practical training sessions were included. This central model was quite rapidly adopted in the medical regions where courses were organised (but not in all of the six regions).

- After this first phase of basic management training (mainly targeted to chiefs of clinics), during the 1980s a series of programmes more focused on psychological leadership became evident. Influences were strong from industry, which in the 1970s had adopted ideas about 'satisfied customers', leadership psychology, etc. A new wave of management courses along this line was developed. Some of the content focusing on health economics and evaluation sciences was abandoned. Central initiatives from management consultants close to the Federation of County Councils were followed by local programmes.
- The third phase, starting around 1990, could be described as a rediscovery of the need for a management training programme for doctors that is once again more focused on skills in and knowledge of health economics (in a wide sense), and health care administration (which is now evolving as a more distinct subject in the medical schools, partly specialising within community medicine or social medicine, technology assessment and quality assurance). Information technology could be another vital part, as well as systems sciences. The main point is that there are certain basic disciplines within the medical faculty and in the social sciences that could form part of the curriculum of administrative training. Alongside this is the psychological aspect of leadership (how the individual and the group work etc.), as well as role models discussed earlier.

An example of this kind of management training is a six-week long programme initiated by the Federation of County Councils in 1992 as a pilot project. The programme was run by the Karolinska Institute (the medical school of Stockholm) and located in the Department of Community Medicine at Huddinge University Hospital. Technically, the programme consisted of three sets of two weeks each over a period of nine months. The content covered a wide variety of the subjects mentioned above. The participants also carried out an in-depth study of an administrative problem in the home setting. This programme with a profound medical profile will be given continuously at the Karolinska Institute. At the moment, it seems to have given rise to several local programmes.

At the Stockholm School of Economics another programme with a focus more on health economics is due to start in Autumn 1993. This

programme is supported by the Federation of County Councils and the Swedish Medical Association. The focus will be on economics and management. Projects with reference to the participants' workplaces will also be included in the curriculum. The formal part of the programme is six weeks. The course is principally intended for people in a management position within the health care sector, and the target groups are physicians and other professionals.

THE FUTURE

It is important that all doctors gain some understanding of management and administration. One way to achieve this would be to offer courses during specialist training on a larger scale. By making such courses available to every doctor at this stage in their career, there would be a common ground on which to base further activities. The goal is that each junior doctor should have a chance to get exposed at least to one such course. All doctors need this amount of training to perform an ordinary clinical task. An important aspect is to introduce young doctors to perspectives outside the field of medicine and prepare them for greater responsibility in management. The experience in Sweden so far is that these courses have been of great value, as they have contributed to making doctors more interested in management issues and have attracted some of them into management.

It is quite clear that it can never be sufficient to offer management development programmes only to those already holding leading posts. In the past this has quite often been the case, partly due to limited resources. Recent developments, however, show that greater emphasis has been placed on recruitment and much effort is dedicated to recruiting the right managers. Personal qualities and leadership ability are seen as more important than clinical background and qualifications. Instead of appointing the most senior doctor as chief consultant, the trend is to choose the doctor seen as most capable of going into this role, regardless of clinical experience. To facilitate appointing the right people to leading positions, future leaders should be identified and actively prepared for management roles. Management development programmes and other activities related to organisational development will be necessary to promote good leadership and to make sure there is a supply of candidates suitable for leading positions. More attention should be paid to planning in advance, including career planning.

It will be more common in the future to have a management position for a defined time period. Different kinds of leadership may be necessary depending on the development phase of the organisation. Expansion is a rather different situation from consolidation or reduction, in economic terms. It is therefore important to create mechanisms for alternation between management and professional/consultant positions. Brush-up programmes may be useful for those who resume their careers as medical specialists.

The rapid changes in medical technology call for a management structure adapted to such changes, i.e. with increased flexibility and possibilities to reallocate resources. One way to bring about this increased efficiency is to organise the delivery of health care in larger units, combining the resources from several clinical departments. Examples of this can be seen in some Swedish hospitals. Leading such large and complex units will require more advanced management training and ability. In Sweden, it is quite common for clinicians in management positions to continue their activities in clinical medicine, perhaps devoting one day a week to seeing patients. However, for doctors managing the large clinical units which are emerging as a result of medical and organisational development, it will be almost impossible to retain some clinical activities and to keep up with professional standards within clinical medicine. They will have to choose: either abandon medicine to become active in management only, or give up a specific management role to concentrate on a career in clinical medicine. In the future more doctors will have to make this choice, perhaps early in their career. Management training, of course, will make it easier to come to a decision. Continuing training will be a must to enable doctors with this broader responsibility to develop as leaders and make them eligible for new appointments in this field.

Doctors who are exclusively active in management will become more similar to general managers, but they will still mainly be managers of clinical resources. With fewer departments and thus fewer managers at this level, it will be less complicated to let these managers take part in the management of a hospital. This will mean giving them a defined role in the management structure alongside the hospital director, who in Sweden, in most cases, is not a physician.

In May 1993 representatives of ten countries met for two days in Dublin, under the auspices of the European Healthcare Management Association, to explore similarities, differences and potential ways forward to strengthen management development for those doctors managing clinical resources.

Prior to the conference, the co-ordinators from each participating country had produced a paper examining the state of management development for doctors in their respective country and identifying strengths and weaknesses in the approaches currently in use; they were also asked to speculate on possible future directions for this work.

Taking the papers as a starting point, there followed highly participative discussions trying to understand 'the reality behind the descriptions'. From this better understanding, several common themes emerged and a number of issues that need to be addressed were identified.

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