KING'S FUND TRAVELLING FELLOWSHIP - 1988

CONSIDERATION OF THE CANADIAN MEDICAL CHIEF OF STAFF ROLE AND ITS SUITABILITY TO THE U.K.

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1. INTRODUCTION

1.1. The aims and objectives given when applying for the King's Fund Travelling Fellowship in 1988 were "to assess and examine at close quarters the Chief of Staff model involving clinicians in the management of hospitals as refined and practised in Canada; to attempt to assess this in the UK context."

1.2 While on a brief visit to Canada - Ontario province - in 1987 to study quality assurance programmes, the Chief of Staff structure for managing medical staff was often referred to and the concept seemed worth a specific study in order to assess whether it could be adapted for introduction in the UK at a time when the involvement of clinicians and self regulatory arrangements therein were featuring prominently on managers' agendas.

1.3 Upon the award of the Fellowship it was possible to associate with the project the Chairman of Barnet Health Authority (a general practitioner and Authority Chairman of 10 years) and a consultant physician, who also serves as the consultant nomination on the DHA. A one week intensive visit by all three was paid in October to five hospitals arranged through Dr. Jack Saunders, Deputy Secretary of the Ontario Medical Association, accompanied by long discussions with him and Dr. Chris Wilson of the Ontario Hospital Association. What follows, whilst being the report of the Fellow, is inevitably influenced and modified by these discussions and others with experience in the attitudes and practices of the UK health service.

1.4 At the suggestion of the King's Fund College some detailed study of the Guy's Hospital initiative for involving doctors in management was carried out before going to Canada - or to be specific, Toronto city, in Ontario which undoubtedly has different characteristics to the other nine provinces other than Ontario in this vast country covering 3.8 million square miles and yet with a population of only approximately 22 million. It is also necessary to have some appreciation both of the size and the relative "newness" of Canada as a nation (it was created as a federal union with provinces in 1867 after total conquest by the British in 1759 and only became an autonomous nation within the Empire in 1931) when undertaking the review embraced in the Fellowship.

2. STRUCTURE AND ORGANISATION OF HEALTH CARE , ONTARIO PROVINCE

2.1 The context in which the Chief of Staff operates is as part of a structure, in which Ontario is one of ten provinces, with considerable autonomy but under an overall federal government umbrella. Ontario is the most heavily populated - over 8m. - and covers 412,582 square miles. Within the province are 220 general hospitals, many of which have under 100 beds. The Canadian federal government has, over the years, superintended the introduction of publicly funded universal health care coverage. Individuals are insured through OHIP (the Ontario Health Insurance Plan) either by direct payment of premiums or by their employers, and OHIP reimburses

physicians on a fee for service basis. The hospitals, in which the physicians will either practice exclusively or jointly from their consulting rooms in their role as family physician or specialist, are mostly non-governmental, each with its own Board of Governors or Trustees, but nevertheless in receipt of global budgets from the provincial Ministry of Health. With doctors paid on a fee for service basis and hospitals with global budgets it is easy to perceive the seed-bed of the struggle we were able to witness in October 1988 of the recently elected Liberal provincial government attempting to control constantly rising costs, with Ministerial rhetoric that could have been uttered in the UK. Ontario hospitals are now having to face non-incremental growth and rolled on deficits are liable to be ignored by the government for the first time; physicians are being accused of excessive treatment, but with an offer of increase on fees at less than inflation still lying, rejected by the OMA, on the table, the good-will of the doctors is no longer to be assumed.

2.2. Universal insurance coverage means that there is no private health care and the only payment permitted for in-patient care is for the equivalent of an NHS amenity bed. The very rich, or the very anxious, will go over the border to the USA for private care and there is some inward flow of Americans, who are charged the full economic in-patient charge, to particular Canadian physicians. As long as this income (and consequent diversion of beds from Canadian nationals) is moderate the Ministry of Health tolerates the situation. In places where it becomes excessive they move by reducing the hospital's budget allocation accordingly. There are one or two small totally private hospitals, specialising in one condition like varicose veins or back pain and one example we saw was where cosmetic and breast surgery was on offer within a hotel complex - the "in-patient" care being given within the main hotel block, adjacent to theatre accommodation.

2.3 Canada is often affected by its proximity to America and although it does select from U.S. experience in adopting new ideas, one common characteristic seems to be in writing things down. Thus it was found that there was often a heavy emphasis on recording procedures, functions, protocols etc. and a preparedness to service mechanisms along these lines. Hence in one hospital visited, with only 316 beds (78 chronic sick) there were 22 committees for physicians to man, ranging from the admission/discharge committee to the organ donation committee, as well as the Medical Advisory Committee and medical representation on seven committees of the Board of Trustees. In a University hospital the Chief of Staff said there were 55 committees and he had calculated that each year he spent 400 hours in committee. The tradition of "writing it down" thus assists the spirit of open-ness which is a characteristic found in Toronto; of recording in preparation for the growing tide of medical litigation; of accurate information flows; of excellent medical records and of the emphasis given in the past two - three years in the establishment of quality assurance mechanisms. It is also the bed-rock of the accreditation process carried out by a provincial agency, and often relying on evidence of compliance through records, while the Surveyors conduct their accreditation visit during a 2 to 5 day

period.

2.4 Written procedures govern the management of individual hospitals and it is significant that the Ontario Medical Association and the Ontario Hospital Association (the latter a mixture of the UK National Association of Health Authorities for representation purposes and the King's Fund for development of new ideas, but relying entirely for its income on the membership of individual hospital boards) jointly produced in 1968 prototype hospital by-laws. The 1984 revision runs to 70 pages, a copy of which is lodged in the King's Fund College library with a copy of this report, and is the basis of management of the corporate affairs of the hospital as well as reflecting the requirements of statute, latterly brought together under the Public Hospitals Act (Revised Regulations of Ontario) 1980. Of the 70 pages, 21 cover administration, 1 nurses, and 29 medical and dental staff.

This emphasis is significant in its regulatory and prescriptive nature, but also arises from the need for procedures to govern the admission to the staff of the hospital of physicians applying for privileges in lieu of the junior staff in UK hospitals (almost non-existent in Toronto non-teaching hospitals) and the elaborate procedures governing the life-time tenure and appointment to the consultant grade appertaining in the UK.

2.5 Appointment to the staff of a hospital is important to the physician practising on a fee for service basis, because working from a consulting room will, of necessity, impose a limitation on earnings potential. All physicians wishing to be granted admitting privileges firstly has to be reviewed and then recommended by the Medical Advisory Committee and thereafter have to be confirmed each year. The power to de-select is obviously important, and is accordingly hedged about with an appeal procedure that seems synonymous with those governing dismissal of a UK consultant.

2.6 In the course of applying for, and accepting privileges, the Ontario physician accepts the need to abide by a set of by-laws that will define in considerable detail a number of procedures governing their acceptance and conduct. Relevant ones are given as Appendix A.

(Taken from the By-laws of York Central Hospital.)

2.7 The model by-laws also set out in detail the duties associated with Department Chiefs and Chief of Staff. It is important to be aware that there is a statutory requirement for a Chief of Staff to be appointed, or some other post created that will embrace the same duties; and that the by-laws, when adopted by the Board of Trustees, have to be confirmed by the Ministry of Health. The fact that the post is enshrined in statute, and accords with the Canadian approach to corporate hospital life, is of significance in assessing its acceptability within the country and its transferability to the UK.

2.8 <u>Department Chiefs</u> are appointable where the size and resources of the department warrants it, and the Board, acting on the advice of its Medical Advisory Committee, recommends it. Once the Department Chief structure has been sanctioned the names of the Department

Chiefs are approved by the Board upon the recommendation of the MAC. The D.Cs would, along with the President of the Medical Staff (elected by all the physicians), and the Chief Executive Officer/Administrator, constitute the MAC under the Chairmanship of the Chief of Staff. The President of the M.S. would also sit with

the Board as a full member. The MAC advises the Board on the quality of medical care - a task taken seriously and made more extant than is the case in the U.K. Thus in the Medical Staff By-laws at York Central Hospital, Toronto, the first responsibility for a Head of Department is clearly expressed as "being responsible for the quality of medical diagnosis, care and treatment provided to the patients and out-patients of his Department." It goes on to pinpoint the responsibility to "discuss with the attending physician" cases where he is made aware that a "serious problem exists in the diagnosis, care or treatment of a patient" and if changes are not made "promptly" the Head may assume control of the patient in place of the errant physician. He may even proceed in such a manner if he "is unable to discuss the problem with the attending physician." A Department Chief may spend 25% of his time on departmental duties, and may be remunerated for this time.

2.9 The Chief of Staff, as has been noted, is a statutory requirement. Here the expectation is that a third of his time will be spent on the task and he is remunerated appropriately . Appointed for three years, renewable once by the MAC, the duties are succinctly set out in the York Central by-laws as:

"(i) Supervise all professional care given to all patients within the hospital.

(ii) Be responsible to the Board for the general clinical organization of the hospital and the supervision of the medical, surgical and obstetrical care given to all patients within the hospital.

(iii) Advise the Medical Advisory Committee with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients of the hospital.

(iv) Act as Chairman of the Medical Advisory Committee.

(v) Be an ex officio member of all committees that report to the Medical Advisory Committee."

The Chief of Staff's responsibility for the "professional care given to all patients" is all embracing and in the ultimate can involve him in having to explain to the hospital Board how any successful litigation could have occurred without his knowledge or anticipation etc. It is apparently a fine issue as to how a CS hears of potential problems before they occur, how he then acts and how he reviews competence. In this function he is helped by the enduring wish of all the staff in the hospital to make it a successful and popular institution; by the close involvement and awareness of

Trustee/Board members in the affairs of the hospital; by the characteristic (as far as could be judged) of open-ness and generally relaxed good humour; by the requirement that all physicians participate in the management and by possessing the ultimate sanction of withdrawal of admitting privileges. The non-adversarial atmosphere is perhaps best illustrated by one C.S who, on being asked a hypothetical question about how he would deal with a surgeon whose temper and language in theatre affected the willingness of nurses to work with him, replied that he actually did have that problem and would be dealing with it imminently by having the surgeon and the senior nurse who had reported it to him in for a joint discussion on the matter. (In similar circumstances in England known to the author, the Regional Medical Officer informally saw the surgeon at the Regional offices, the surgeon accompanied by his professional insurance body representative and with no nurse present.) The Chief of Staff is not helped by the element of "election", via the MAC, after soundings and by the need for renewal at the end of three years. The inability, in the model by-laws, for a further term of office without a mandatory break of at least one year, also weakens continuity. One is reminded of the process by which Deans of UK Medical Schools emerge in a similar way, and which sometimes gives rise to "weak" or "popular" Deans, but in some cases where, equally, persons of great strength of character have wielded much influence for the good not only of the School, but also in the associated hospital.

2.10 Thus far the formal requirement of medical managerial posts have been given. An evaluation on the basis of one week is impossible; an assessment concludes this paper. Clearly the arrangements as laid down have given structure and a hierachy to medical management in the Country. At a mundane level this has ensured that minor deviant behaviour (like failure to keep medical records up to date or discharge summaries completed within a set time) is tackled; there is the re-assurance for the public about the watching brief on quality of medical care. Inevitably some physicians took it seriously and provided dynamic leadership over and above the by-law requirements; others were shallow men who merely kept the peace and the wheels of medical governance moving. With many hospitals being 100 beds or under this structure could be likened to insisting that the Chairman of a Medical Committee in a similar size hospital in England undertook some specific duties and was held accountable for them.

However, upon closer examination, this Canadian system is now undergoing modification in the light of experience, and a new range of appointments are sometimes now being made in hospitals in Ontario province. These are discussed in the following section.

3. NEW MANAGEMENT STRUCTURES EMERGING

3.1 Following an introduction from the Ontario Hospital Association to the Ontario Medical Association, the Fellow's programme was designed by the OMA and enabled a range of approaches to the C.S. task to be discussed with different participants. The programme was only tabled on the first day of arrival. All the hospitals were fairly

easily accessible from Toronto, and so were either large, teaching hospitals or smaller, "community hospitals" with tertiary referrals to the centre. One chronic sick hospital was visited; but no psychiatric hospital. We only met with physicians who had a commitment, or interest. None were notable failures.

3.2 A word of explanation about the new pressures is needed in order to better assess the modifications being introduced by various of the hospitals visited.

The Canadian system of universal, free coverage is relatively new and most certainly still very popular. In 1957 less than half of Canadian citizens had any form of health insurance; by 1961 all ten provinces had instituted a universal hospital insurance programme and by 1970 universal health insurance was established - very different in approach to that of the neighbouring USA. There were various milestones along this road of achievement, and the inter-play of federal (central) government responsible for health matters that transcended (the ten) provincial government boundaries was important. One such was the 1955 Federal-Provincial conference at which Prime Minister Lester Pearson offered cost sharing grants whereby federal government would subsidize 50% of provincial costs for services provided by physicians and specialists under the fee for service scheme provided provinces could show universality of schemes, and within 2 years. By 1971 all citizens in all provinces were fully covered but by 1977 the Established Program Fiscal Act had to be introduced in order to institute federal control over provincial spending and because federal cover was skewing the balance of development of health services overall. The 1977 EPF Act allotted money to a predetermined amount to hospitals in the expectation that they would stay within budget and put control down to the provincial government. Financial control over hospitals budgets, whilst rigorous, had until recently the expectation that an over-spent institution would be reprimanded, but assisted and its over-expenditure reflected in the level of the grant made in the ensuing year. The present Ontario government is taking a tougher line on deficits.

3.3. Thus, in sharpened form, the issue is arising as to how to reconcile management, working to a fixed budget, with doctors, working on a volume driven/financial reimbursement system. The fee for service aspect is increasingly subject to greater control through governments fixing the budget. One President (akin to a DGM), asked how he would reconcile this conflict, replied by "good will and trust", but had altered his management structure, creating a whole time Vice-President (Medicine) to manage the conflict. (See following). Another hospital, returning a deficit of $1.5 Canadian dollars was visited by a Ministry Special Investigating Team. The outcome was that their budget was increased by 1.57m. Canadian dollars, but suggestions for economy like combining the ITU with the ICU and the establishment of an Impact Analysis Review Process for new posts (in itself a two page questionnaire designed to relate new posts to existing policy and directional changes, plus impact on other functions) had to be introduced.

3.4 The present system militates against any planning - in manpower (and medical over-manning in attractive areas like Toronto is becoming a major problem), services (relying very much on voluntary consortia, with occasional directional help from government via capital grants or with-holding permission for developments) and the overall direction of the service, still with severe limitations on home care and long stay/chronic services. In some ways, in 1988, one had the feeling of being present at the end of an era and certainly morale was lower, bitterness toward the provincial government more in evidence and a slow groping toward cost containment getting under way. The acute hospital sector is beginning to feel the effects of the more critical line being taken by the Minister of Health.

Some new structures examined now follow.

3.5 <u>Full-time Chairman of the Medical Advisory Committee</u>

This incumbent, in a large teaching hospital, is the professional medical administrator, reporting to the President of the hospital. He carried out all the functions of a Chief of Staff in relation to medical, matters - quality, discipline and overall "Mr. Fix-it" - but clearly saw the need to ensure greater physician participation in order to withstand the threats of government intervention and increasing cost control. The same hospital had recently drawn up its Strategic Plan, giving nine areas for development out of 77 listed for consideration. This had been arrived at by a joint Board, doctors and administration task force and henceforth nothing would be allowed to alter these plans. He was committed to it and would control it. Costing, and the exact determination of costs, was still in its infancy.

3.6 <u>The Vice President (Medical)</u>

A new post, creating a salaried position in a 540 bed hospital, with a former Chief of Staff from another hospital appointed and responsible to the (lay) President whose responsibilities appeared to be akin to a District General Manager.

This post combined Chief of Staff with line responsibility for x-ray, pathology, and quality assurance. The North York Hospital chart is attached (page 9). New ideas here were for a joint medical and administration working party on priorities, that look at administrative developments as well as medical ones, thus overcoming the lack of appreciation of administrative needs by doctors and breaking out of the restriction by doctors to matters of medical expenditure only. The medical staff have been given the medical equipment budget, have full responsibility for it and the Board of Governors accept their recommendations. A recent innovation, stimulated by crisis, was the physician managed admission system where the physicians controlled the allocation of beds, revised their distribution according to past experience, utilisation etc. and with one physician responsible for coordination and admission procedures. The problem of "outliers" was improving accordingly.

The President was aware of new developments, like the programme management system (very much the UK Management budgeting system) but did not intend to introduce it locally because it would entail revolutionising all the traditional ways of managing.

NORTH YORK GENERAL HOSPITAL

- NYGH FOUNDATION
- BOARD OF VOLUNTEERS
- IODE BOARD
- MISSIONARY HEALTH INSTITUTE

The founding fathers that created the hospital.

BOARD OF GOVERNORS
W.M.E. McLeod

PRESIDENT / CEO
H. Martin

- COMMITTEES OF BOARD
- MEDICAL STAFF ASSOCIATION — 2 members on Board.
- MEDICAL ADVISORY COMMITTEE Chairman on Board.
- MAC COMMITTEES

ADMINISTRATOR
SENIORS' HEALTH CENTRE
D. Anderson

- Nursing Home Services
- Day Centre
- Seniors Assessment Services
- Chiropody

- Pastoral Care
- Administrative Resident

VICE-PRESIDENT HOSPITAL & INFORMATION SERVICES
W. Nelson

- Health Records
- Patient Placement
  - Admitting
  - Discharge Planning
- Psychology
- Social Work and Outpatient Mental Health Services
- Computer Services

Cardio-Pulmonary and Ambulatory Care Services

- Auditory-Verbal Therapy
- Audiology Services
- Child Development & Counselling Serv.
- Diabetic Day Care
- EEG/EMG
- Genetic Counsel./ Cytogenetics Services
- Maternal/Infant Services
- Speech/Language Pathology

VICE-PRESIDENT SUPPORT SERVICES
C. Bloomfield

- Communications
- Dietetic Services
- Engineering
- Fire Safety
- Housekeeping
- Maintenance
  - Courier Transp.
  - TV Rentals
- Security & Parking
- Facilities Planning

VICE-PRESIDENT MEDICAL AFFAIRS
M.P. Granger, M.D

- Laboratories
- Diagnostic Imaging
- Quality Assurance /Risk Management
- Medical Education
- Medical Administration

VICE-PRESIDENT PATIENT SERVICES
B. Rinneard

- Nursing
  - Day Surgery
  - Emergency
  - In-patient Units
  - Intravenous Therapy
  - Labour & Delivery
  - Operating Suite
- Occupational Therapy
- Physiotherapy
- Gerontological Nurse Specialist
- Infection Control Nurse
- Palliative Care Co-ordinator
- Public Health & Home Care Liaison

VICE-PRESIDENT FINANCIAL SERVICES
D. Lane

- Finance
- Accounting
- Business Office
- Materials Management
  - Purchasing
  - Central Supply
  - Central Stores & Printing
  - Laundry & Linen
- Pharmacy
- Marketing
- Financial Analyst

VICE-PRESIDENT HUMAN RESOURCES
A. Odorico

- Personnel/Labour Relations
- Volunteers
- Library
- Education Services
  - Health Promotion
  - Audio Visual Services
  - Staff Development
- Occupational Health & Safety
- Community Relations

October 1, 1988

3.7 Vice President (Medical Affairs), Chronic Sick Hospital

A 600 bed hospital, 200 of which are in the rehabilitation programme. No open access to physicians and all patients admitted are under an Attending Physician or whole time member of staff. The hospital had created Service Chiefs (see below) in 1975 after a review to determine where the hospital was going and what its function was to be and had led to "service programmes" for geriatrics, rehabilitation, EMI etc. Service Chiefs remunerated according to the time they spend on such duties.

3.8 The Sunnybrook Model

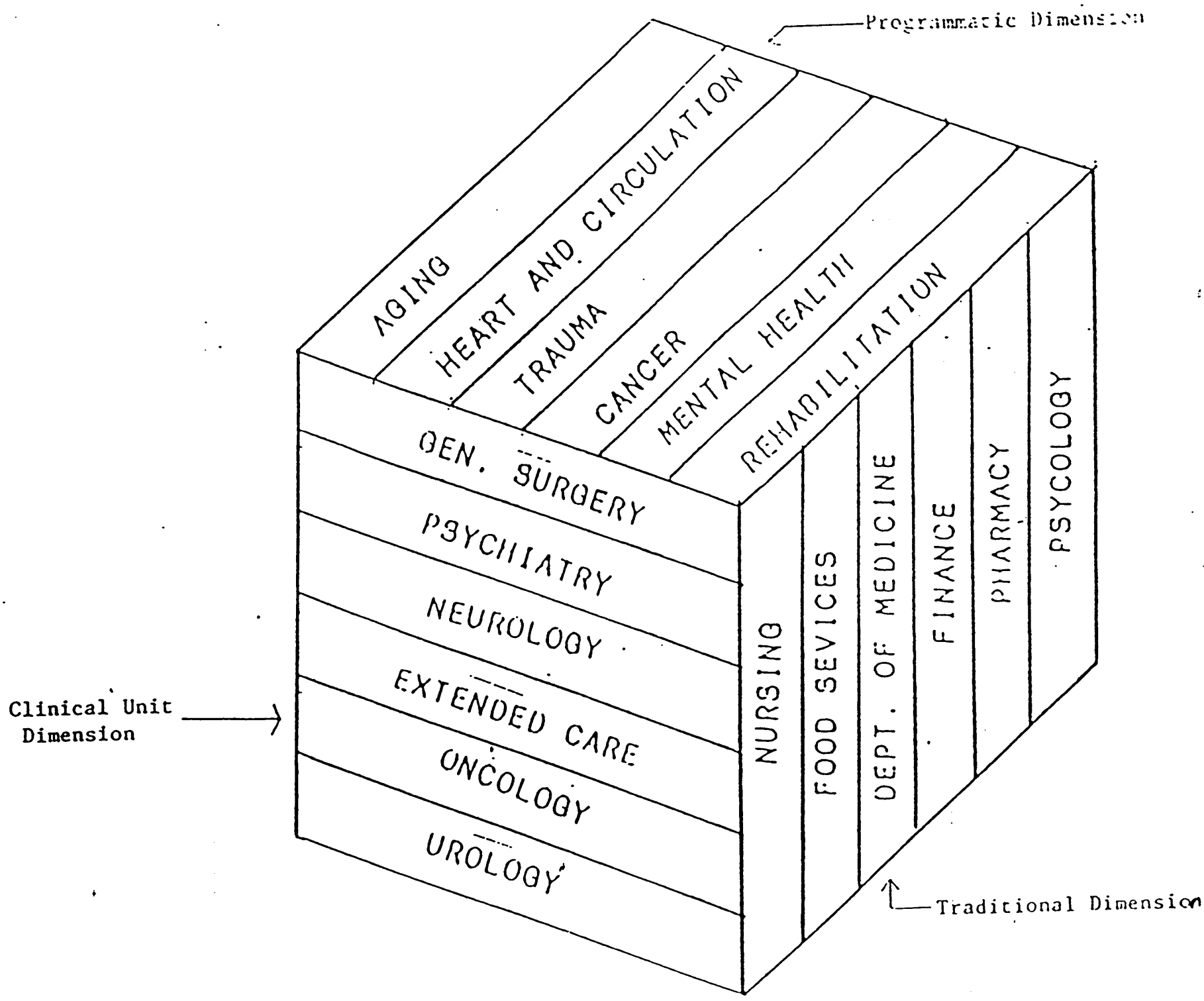
Sunnybrook Hospital is a large teaching hospital, with 650 acute beds (16,352 admissions; no obstetrics or paediatrics but 38,734 casualties) and 570 continuing care beds. The latter was the basis of its original creation as a Veterans Hospital and in the mid-1960s it became a University Hospital and so was in effect a new hospital, with new staff and new approaches. It had developed steadily and by early 1980s had a 12m. dollar deficit and so in 1984 had to decide where it would focus its energies and do well. A Mission Task Force defined six areas for development and so the organisation of the hospital was changed to six main clincial areas: General surgery, neurology, psychiatry, extended care, oncology and urology. There was further devised 6 programme areas, viz: aging; cardiology; trauma; cancer; mental health; and rehabilitation. As all crossed traditional departmental boundaries it was thought appropriate to devise a structure to reflect this. Each of the six programmes now has a clinical Programme Director to lead the programme, and has responsibilities for the budget, the appointment and development of staff, operational efficiency and controlling their unit costs. The "traditional departments" like nursing, pharmacy, pathology supply the inputs for patient care, ensure that professional integrity is maximised and that the professional voice is still heard in the planning process. The professional department keeps responsibility for the unit cost, but not the volume of work done - that is for the programmes/users. This is displayed in diagrammatic form on page 11.

The clinical unit dimension is involving doctors in the management process, making them accountable for resource utilization and understanding that the hospital's "output" is patients. Their major responsibilities are (a) management of patient volume and case mix; (b) budget determination through patient specific costing system; (c) allocation of budgets through negotiation with the traditional departments and (d) monitoring of the multi-disciplinary quality of care.

The programme side, with a Clinical Director, must ensure that they meet their mission goals before developing any special interests. This entails resolving any conflicts of interest between service, costs, teaching, and serving the locality and a need to ensure that the expectations of the programmes are met, and will continue to be met, by the clinical units.

The Board's President, Peter Ellis, an ex-English administrator who left at the 1974 reorganisation, feels that his thinking has moved away from managing departments to managing patients, and that this has been been assisted by the introduction of a computerised medical information system (by IBM & Baxter). This has been expensive (2% of budget and likely to be 2.5% ultimately) but will be complete in 6-12 months. Already in are pharmacy, nursing x-ray, diets, EEG, physiotherapy, with pathology proving difficult. Programme costing is still going in.

A Rubik cube diagram gives the inter-action of the traditional departments, the new clinical units and the defined 6 areas of programme the hospital has resolved to pursue.



SUNNYBROOK MEDICAL CENTRE

ORGANIZATIONAL MODEL

The clinical units will be in Departments, each with a Head. In the teaching hospital context this will be a joint university and hospital appointment. The Head of Department will be selected after a Search Committee and it is intended to bring in new blood. The Head of Department is in a powerful position over promotions, use of resources, allocation of theatre and other time etc. The HDs will report to the Vice-President (Medical) who will facilitate their work and be responsible for the quality of medical care.

3.9 Sunnybrook is in the vanguard of new thinking and is clearly ahead of its time in Toronto. They have linked themselves with other like-thinking hospitals - Guys, Southampton General, Utrecht and Johns Hopkins - and all faced some major local crisis that brought them up against a realisation that they could no longer continue as they were. This group's advice is to involve physicians, and to focus the institution to do certain tasks, like the Sunnybrook restricted six programmes.

4. BRADBEER REVISITED

4.1 In March 1950 Alderman A F Bradbeer was appointed to chair a U.K. Committee of the Minister of Health's Central Health Services Council on the internal administration of hospitals, and the report which carries his name was published in August 1954. Of the remaining 19 members, 6 were doctors, 5 were administrators and 2 nurses. It was the Bradbeer Report that was to set the scene for the tripartite pattern of administration - medical, nursing and administration - which lasted until the 1974 reorganisation substantially modified it, whilst still retaining the concept of partnership in day to day affairs and a substantial presence of medical staff at Authority level.

4.2 In 1988 it is easy to forget the Bradbeer report, but in its day it was seminal and the report had to be reprinted to meet continued demand and interest. The Committee was constituted in response to the problems created by the grouping of hospitals in 1948, rather than allowing them to continue to function as autonomous units or within the local authority structure. In the course of its deliberations it considered, and refined, two structural options that have claimed the attention of this Fellowship - medical superintendents and the Chief of Staff position.

4.3 It is instructive to read in the Bradbeer report that prior to nationalisation of all hospitals in 1948 the voluntary hospitals entrusted medical administration to the medical committee, which comprised visiting physicians and surgeons and that this committee would be responsible for recommending developments and improvements; "to report regularly on the quality of that service; coordination of medical work, including allocation of facilities; and recommendations on new appointments". These are in many ways the same as for Medical Advisory Committees in Ontario. In the local authority run hospitals administration was under the medical officer of health whose representative at each hospital was the medical superintendent, who was also considered to be in charge of all the

beds and overall responsible for the lay and nursing services. How far the medical superintendent undertook active clinical work varied according to individual predilection and the size of the hospital. The advent of the NHS abolished the control of all beds by the superintendent in favour of individual consultant allocations and, after 1949, a distinct bias against whole time medical superintendents emanated from the Ministry of Health, which resulted in the post no longer being the most highly paid one in the hospital.

In the UK we therefore began to deliberately shed what formalised structures there were for management of medical staff in the early 1950s. This was confirmed by the Bradbeer report in 1954 which preferred to see more use made of the chairman of the medical committee, with the possibility of a part-time medical administrator in large hospitals, work within the new tripartite structure. The succeeding efforts to create and sustain new structures for changed times, like the creation of Divisions as part of the "Cogwheel" concept in 1967, would be but an interesting diversion for the purposes of this report.

4.4 But before leaving Bradbeer recognition must be given to the fact that this report, and its acceptability by the government, also meant the rejection of the Chief of Staff post. The Committee fully considered the North American structure and its applicability to England and Wales. It noted the advantages claimed in its operation in Canada and the United States, but concluded "we do not think that its incorporation into English hospitals would be an effective or even practicable answer to our own problems of medical staffing and coordination." They saw in Canada the large number of doctors with admitting rights and the prevalence of private practice as requiring a structure to "prevent the less experienced members of staff attempting work beyond their capacity". They noted the distinction in England where specialty groupings discussed the organisation of the clinical work rather than the detailed review of clinical case-work, and this important distinction still holds true to this day. Some initial impetus was given to what was to emerge as Cogwheel structure by the Committee's support for organising specialties or groups of specialties under the administrative charge of named consultants acting in co-operation with the approved medical administrative machine, in order to arrange medical duties, holiday cover etc. Even this was not to be imposed: "a freely developing service must be given room to manoeuvre and not to be tied down to one rigid administrative formula. And it would be not only unwise but clearly impracticable to try and introduce such a change without the full support and agreement of the medical profession".

5. GUY'S HOSPITAL AND INVOLVING DOCTORS IN MANAGEMENT

Before the concluding section, attempting to assess the applicability of the Canadian experience to the English scene, the Guy's experiment needs to be briefly described. This is not only because it is the best documented English experiment, but also because its significance has also been noted in Toronto - see paragraph 3.9 above.

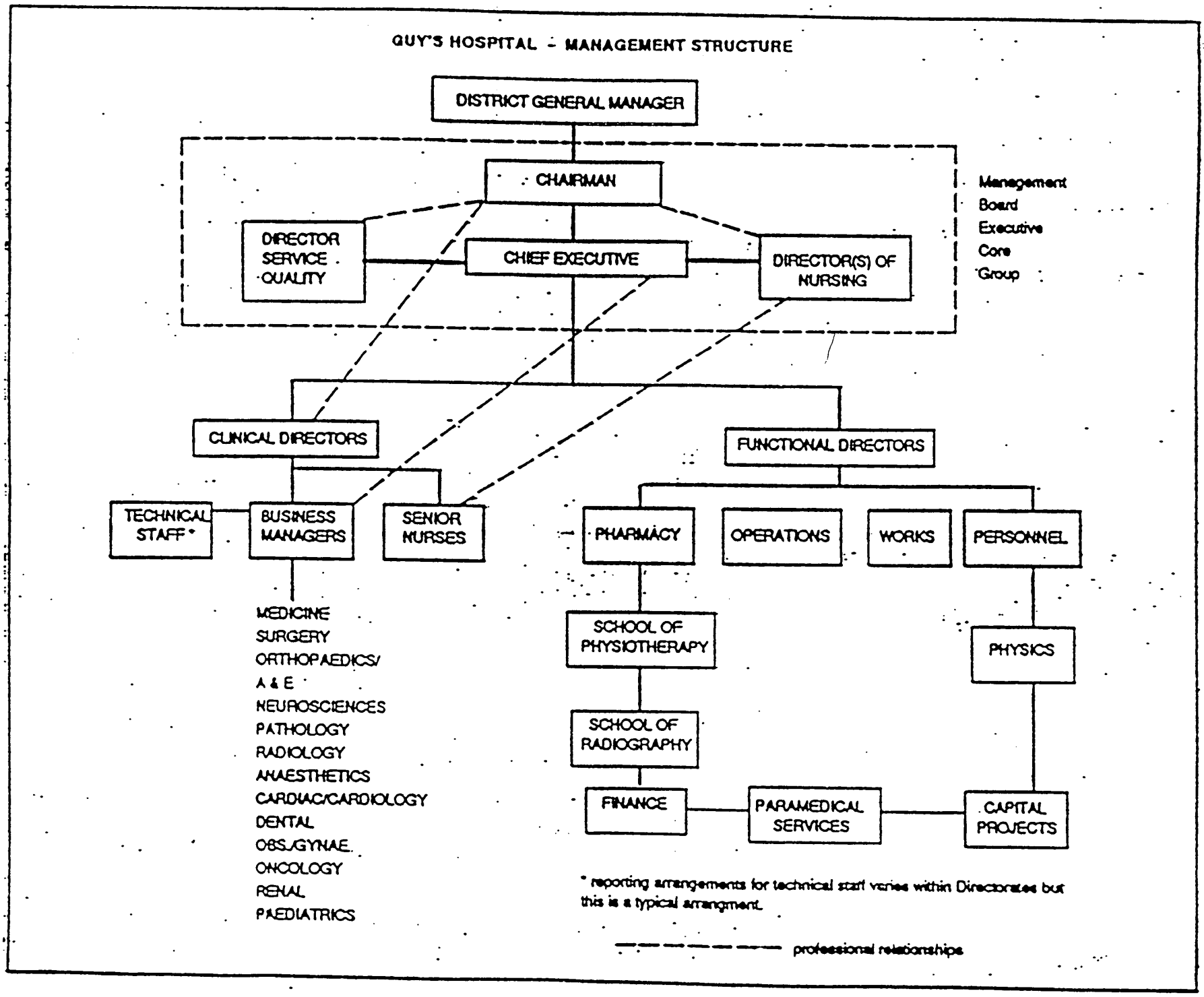
5.1 The experiences of Guy's Hospital, London have been well written up

King's Fund College International Fellowship Report by Professor Cyril Chantler entitled "Guy's Hospital 1985-1988, A Case Study". There is also an article by N. Smith and C. Chantler in Public Finance and Accountancy, issue of November 6th 1987 (Partnership for Progress) and a video issued by the NHS Management Board in the autumn of 1988 about resource management at Guy's, which is inextricably part of the same review. Guy's Hospital itself has produced a quantity of duplicated literature and fuller information needs should be satisfied by referring to the Chief Executive at the Hospital.

5.2 In essence Guy's had, up until 1985, functioned in the accustomed manner with consultants having no "ownership" of the financial health of the institution, regarding themselves as Smith and Chantler put it, of "working within the NHS rather than for it." After some years of vicissitude 1974-1983, a crisis point was reached in January 1984 when 100 beds were closed for economic reasons. Professor Chantler's Fellowship report notes that this led to a "crisis of management within the institution" with administrators feeling they had no responsible advice or help from the medical advisory structure and the consultants angry at their inability to treat patients, and a feeling that "the administrators had lost their vision of the aims of the hospital to care for the sick". During the same period the management inquiry into the effective use and management of manpower and related resources under Mr. (now Sir) Roy Griffiths was announced in February 1983, and ideas arising from the inquiry were in the air until the issue of the report in October that same year, with government support and an implementation plan promulgated in June 1984. Guy's were very much aware of all this and had met with the Inquiry Team, discussing how clinicians should be involved in the management of the hospital with their own budgets related to the clinical service provided and with a decentralisation of services sofar as was possible.

5.3 The major contribution by Guy's has been in its modification of the United States post of chief of department/clinical head of service to be introduced to an English hospital as a Clinical Director. A group from Guy's visited Johns Hopkins Hospital in Baltimore in early 1984 and by late 1984 were agreed upon the need to introduce, from April 1985, a system that reconciled clinical freedom with management authority and accountability, giving consultants power but with responsibility, devolved management but with financial accountability. This, of course, is to greatly simplify the internal debates, the anxieties both by clinicians no longer working within long-standing attitudes or the administrators transferring authority acquired since 1948.

5.4 The Guy's structure is illustrated below.



The clinical Directorates, are each headed by a doctor, the Clinical Director, appointed to these duties for three years, subject to personal performance review and nominally remunerated, with the assistance of a Senior Nurse and Business Manager on the Administrative and Clerical grades from 4 - 23. The Clinical Director is responsible for his budget (about 2/3 of the hospital's workforce is now into such budgets); out-patient arrangements and kindred medical records; consumer/complaints issues; quality targets and quality assurance; responsible and accountable for consultants and other medical staff in their directorate.

The position of Chairman of the hospital management board, finally

responsible for the performance of the hospital, and reporting directly to the district general manager and DHA is interesting in that it combines much of the Canadian Chief of Staff with that of the English Unit General Manager, but without the emphasis formally laid on the Canadians for the quality of outcome of patient care.

5.5 The detail of the budgeting and financial arrangements are not relevant to this study, except to reiterate that it is a vital component (if not indeed an essential pre-requisite) in the exercise. Interim evaluation claims success, as well as more development work needed, particularly in respect of integrating the remaining one-third service areas and of clarifying roles and responsibilities throughout the structure. Predictions for the future are premature, but appear to be that the significance and role of the Business Manager in the clinical directorate will increase, and that more explicit objective setting will occur.

5.6 A modified Guy's structure is in operation at Lewisham Hospital, the sister DGH in the Lewisham and North Southwark Health Authority, where 8 Clinical Directorates are functioning, with nurse and business manager support. There is a broader based United Management Board, with the UGM, all the Clinical Directors, Vice Chairman of the Medical Committee, Director of Nursing Services, Director of Midwifery Services, Unit Finance Officer, Unit Policy and Planning Officer, Unit Personnel Officer and the Chief Pharmacist. The interim view here is that the major effect of the past three years has been in improving budgetary information and control; and that some Clinical Directorates have tackled problems with notable success.

6. SUITABILITY OF CHIEF OF STAFF STRUCTURE TO THE UK

6.1 The short answer to the question whether or not the Chief of Staff structure can be transplanted into the UK is `no'; whether it can be adapted for UK purposes is a more conditional negative, but there are nevertheless some lessons to be learned both from Canada and from qualified new directional pointers in England.

6.2 The Chief of Staff structure has undoubted benefits and in concluding that it is not suitable it must be recognised that we forego these benefits - at least in the immediate future. On the other hand these potential benefits are so entangled in issues sofar without lasting solutions in England, that this is one major factor in considering the whole issue. The tangle of issues that I see a Chief of Staff offering the potential (not the certainty) to tackle and either modify, resolve or improve are: the safeguarding of the individual patient; involvement of clinicians in resource management and outcomes therefrom; shared ownership of the management of the institution or service, and an opportunity to answer the question posed in a BMJ leading article, 25.6.88, "Doctors and managers: never the twain shall meet?"

6.3 It is necessary to explore in more detail why the C.S. concept is not suitable. Firstly it would be a revolutionary change.

Revolutionary change can of course be engineered by statute and it is possible to contemplate a North American structure being imposed, with the attendant problems. The Griffiths report on general management was imposed to some degree, but did also have a lot of informed support. Experience here three and four years on does, however, lead to the conclusion that the health service has an infinite capacity to adapt and successfully implement new ideas and so imposition of the C.S. idea is not entirely unrealistic.

6.4 Secondly, and in order to succeed, it is better to proceed by acceptance, or evolution, rather than revolution. You cannot have a solution without a problem and if the consultant medical staff do not see a major problem in our present arrangements (and there is little evidence of this) then you cannot talk in order to find a solution.

6.5 If nationally there is no perception of a problem then perhaps a crisis is needed to precipitate a local solution - third point. This has been the experience of the five hospitals referred to in paragraph 3.9, and we are fortunate in the case of Guy's Hospital that they have written this up, with some candour. Most other hospitals in the UK, who have been through similar vicissitudes (but perhaps not on such a scale and over such a long period of time), have still not either seen the crisis, or been able (or prepared) to see it as one capable of solution at a local level. Instead the bulk of hospitals have institutionalised the conflict and crisis somehow, battened down the hatches, made their economies, ground through change with varying degrees of success and have in all probability paid a heavy, invisible, price in terms of morale. It is salutary to note that the Ontario hospitals, faced with the UK experience in terms of government requirements over expenditure, have begun to move away from the Chief of Staff mode to others, and as the going gets tougher it is possible to speculate that this thinking and structures may change yet again.

6.6 Fourth, is the cultural differences between the two countries. This has been discussed already in paragraphs 2.3 and 2.4. Hierarchy is almost a dirty word once you have reached the status of consultant and the C.S. model involves accepting a hierarchy. The feelings that led Bradbeer to reject the idea in 1954 would still be quickly found today, except that today peer review is in its infancy. Furthermore, no sanctions, like removal of admitting privileges begin to even remotely exist in England. Some, like Scrivens (BMJ, 25.6.88, vol. 296) have argued that management education is an essential part of medical undergraduate education, requiring at the same time a modification of present attitudes which teaches "the best interests of the patient" irrespective of the organisation, or the context in which state provided medicine may carry attendant obligations. The revolution in medical undergraduate education has not yet begun, thus further reducing any climate of acceptability of change in the medium term.

6.7 The fifth reason is attitudinal. North American physicians regard the hospital as an asset - it gives them admitting rights and hence income - whereas attitudes by English consultants towards hospitals

vary. To some the weight of tradition weighs heavily and their loyalty to the hospital is expected upon appointment and remains. (This appears to be one of the ingredients in the success of the resource management initiative at the Royal Hampshire County Hospital, Winchester; and certainly was one of the factors at Guy's Hospital in their moment of crisis.) To others it is a work-site, visited for sessional commitments and not commanding any particular loyalty. To some loyalty and commitment is given to the profession, via their professional college. Some, so I am told, regard the hospitals "as a bureaucracy which gets between the doctor and the patient." The effect overall of politicians and their relationship with the medical profession is ultimately worked out in the local hospital context, and there have been a number of tensions, particularly since the private beds issue started by Mrs. Barbara Castle in 1974/5. In 1988 Toronto the attacks by the minister on medical levels of expenditure and on fee levels, had started to breed a feeling of resentment against the government executive and a move to form a unified line of defence with the hospital managers - advocated by the Ontario Medical Association. But if the hospital managers were to become the agents of government (as Steve Harrison postulates they are in the UK, see Managing in the Health Service: shifting the frontier? Chapman & Hall, 1988) this too would have the effect of loosening the ties, loyalty and commitment to the hospital.

6.8 Five reasons why not - but that is not to rule out that occasionally a leader is thrown up, or emerges by sheer force of personality, and acts de facto in the Chief of Staff mould in terms of exerting discipline, rounding up out-lyers, starting debate or, as Guy's describe it being done by Professor Chantler, "imposing, politicking, fighting, bargaining, compromising."

6.9 Reference was made at the outset to involving clinicians in management being on managers' agendas in 1987, and so it has remained during 1988, and so it is likely to continue to remain. The challenge is to develop managers and management style that have enough skill and perception to manage professionals, and particularly doctors, in a constructive and non-prescriptive manner. Increasingly, and encouragingly, it is being openly discussed and some empirical work (like the Templeton Series, no. 5 Managing with Doctors: Working Together?) has been done. Thinking about the issue, and travelling to Canada, has led me to conclude that the resource management initiative does in fact offer the best way forward. The word "forward" is used advisedly because current pressures from the centre are not likely to abate and the tensions that exist between doctors and management (for a variety of reasons) need to be reduced, or even eliminated, by some new process that will provide common middle ground.

Others are evaluating resource management, and this is essential, both in terms of outcomes and in order to assess what the actual costs of implementation are. Thereafter the service can assess whether the end product is worth the price it will have to pay. It looks as if it will, and that clinicians will be willing to be led into a partnership over resource allocation and control, in return

for the transfer to them of a good deal of authority and responsibility. The question of what sanctions to apply (what they are, how to apply and by whom and when) still remains and will, in the ultimate, be a necessary item of last resort. And we must also remember that in the UK we still have no one person to "supervise" all professional care given to all the patients within the hospital" (York Central Hospital By-laws) and that this is very likely a matter that public opinion will ultimately, and rightly, expect to see addressed.

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I would like to acknowledge the generosity of the King Edward VII Hospital Fund for London in awarding a Travelling Fellowship, and to Barnet Health Authority for granting both the time and the stimulus to undertake it. There is undoubtedly much of value to be learned from Canada, an under-rated country, quietly different from America, and often the better for it.

Nigel Weaver

APPENDIX A

Extracts from by-laws of York Central Hospital

" (a) Viewing Operations or Procedures

Any operation or procedure performed in the hospital may be viewed without the permission of the physician by:

(a) the Chief of the Medical Staff, or delegate, or
(b) the Chief of the department, or delegate.

(b) Duties General

1. Every member of the medical staff shall co-operate with:

(a) the Chief of Staff and the Medical Advisory Committee:

(b) the Chief of the department to which the physician has been assigned;

(c) the President of the medical staff; and

(d) the Chief Executive Officer.

2. Each member of the medical staff shall:

(a) attend and treat patients within the limits of the privileges granted by the Board, unless the privileges are otherwise restricted.

(b) notify the Chief Executive Officer of any change in the licence to practise medicine made by the College of Physicians and Surgeons of Ontario;

(c) abide by the rules of the medical staff;

(d) give such instruction as is required for the education of other members of the medical and hospital staff;

(e) perform such other duties as may be prescribed from time to time by, or under the authority of, the Medical Advisory Committee.

(c) Consultations

1. The medical staff shall establish rules to govern obligatory consultations.

2. The attending physician shall have consultation with one or more members of the active staff:

   (a) on every patient who is recommended for an operation, but whose condition is such as to indicate that the patient may be a poor operative risk;

   (b) on every patient where there is a failure to progress as expected under treatment;

   (c) on every patient where a serious problem of diagnosis or management exists; and

   (d) all other cases in which the rules of the Hospital require that a consultation be requested.

(d) Attendance at Meetings

2. Each member of the active and associate staff groups shall attend 50 percent of the regular staff meetings and 70 percent of the meetings of the department of which he is a member.

3. If any member of the medical staff, without written reasons acceptable to the Medical Advisory Committee, does not attend the required number of meetings in the calendar year, the Committee shall recommend to the Board that the delinquent member:

   (a) be removed from the medical staff of the Hospital; or

   (b) be suspended from the medical staff of the Hospital for a specified period of time; or

   (c) work within certain restrictions upon his Hospital privileges for a specified period of time.

4. (a) When the case of a patient who has been examined by, operated on by, or has received treatment from a member of the medical staff, is to be presented at a general or departmental staff meeting or at a meeting of the Medical Advisory Committee, the physician who examined, operated on or treated the patients shall be given at least forty-eight hours notice by a medical staff officer and shall attend such meeting prepared to present and discuss the case.

   (b) Failure of a member to comply with this may result in disciplinary action being taken against him as provided in subsection (3).

(e) Supervision of Associate Staff Member
(i.e. an applicant serving a probationary period)
3. The supervision of an associate staff member shall be as follows:

(a) The associate shall be monitored by supervisor(s) appointed by the Chairman of the department who shall

(i) observe the assigned associate's performance of procedures and practice in the Hospital;

(ii) review the associate's charts and work in order to evaluate the competence of the associate;

(iii) guide and advise the associate member in medical staff organization and procedures;

(iv) encourage appropriate use of the Hospital's facilities.

(b) Supervisors may be changed during the initial six (6) months of probation so that as many members of the department get to know the associate and the way in which the associate works.

4. At the end of six (6) months the Chairman and the supervisor(s) shall review all aspects of the associate's work and conduct and make written recommendations as to continuance of privileges. The report of the supervisor(s) shall include:

(a) the number of patients treated and procedures done by the associate;

(b) indications for an appropriateness of diagnosis and management;

(c) comments on the associate's quality of care and record keeping;

(d) comments on the use of Hospital facilities; and

(e) comments on the conduct of the associate.

(f) Medical Audit Committee Duties

a) shall:

(iv) review all Hospital deaths to assess the quality of care that has been provided;

(v) identify the continuing medical educational needs of the medical staff.

b) perform such further duties as the Medical Advisory Committee may direct concerning the quality and quantity of professional work being performed in any department of the medical staff to the hospital."