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New development: Clinicians in management—past, present, future?

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IMPACT
This article will be of value to health policy-makers, care regulators, service leaders and professional bodies who are collectively grappling with how best to ensure that governance structures and procedures are more effective in detecting and responding to the signs of variable care quality. Specifically, it supports and extends a growing body of evidence showing that greater involvement of healthcare professionals in senior management is positively associated with increased care quality and safety. It looks at the recent research supporting these ideas and outlines new directions for future research and practices development.

ABSTRACT
There is growing evidence that greater involvement of healthcare professionals in the governance of care organizations is positively associated with increased care quality and safety. Recent research further suggests that a critical mass of doctors can help senior management in delivering on their governance responsibilities. Prompted by a recent article in *Public Money & Management* by Kirkpatrick et al. (2023), this article looks at the past, present and future of clinical involvement in healthcare management. As well as locating this growing body of research in wider social science debates, it outlines a number of potential lines for future enquiry.

KEYWORDS
Clinicians; doctors; hybrids; management; performance; quality; safety

Introduction

In light of continuing and recent concerns about the capacity of senior managers to appropriately respond to the warning signs of poor-quality or even dangerous care (Dyer, 2023), there is a pressing need to better value the contributions that healthcare professionals can make in hospital governance, especially in providing essential clinical insight and intelligence when assessing the standards of care and in informing decisive action. As shown in my own research on the governance of integrated care systems, the contribution of clinical leaders to health system governance can range from providing analytical insights in strategy formulation, representing the views of clinicians in decision-making, communicating strategies in favourable ways and mediating conflict between professionals (Waring et al., 2023). Over the last decade, Kirkpatrick and colleagues have produced an impressive body of research making significant empirical, theoretical and methodological contributions to our understanding of the role of doctors in senior management. Within *Public Money & Management*, Kirkpatrick et al. (2023) recently provided another important analysis of the positive contributions doctors, especially acting as a critical mass, can make in the governance of healthcare quality and safety. In this article, I locate this corpus of work in the broader debates about medicine and management (*past*) and then focus on the specific ideas developed in their article (*present*), before considering how this programme of research might be progressed in light of changing patterns of healthcare governance (*future*).

Past: locating the role of clinicians in management

Doctors' and nurses' involvement in the 'administration' of care services is not new. Senior members of these professions have long had roles in organizing hospital work, from the iconic ward matron to the hospital chief physician. That said, something changed over the last four decades that signalled a transition from an 'old' to the 'new' era of professionals in hospital governance, and that change was (and is) the ascendance of management as a dominant logic for organizing healthcare. A rich literature describes the corporatization and managerialization of Western healthcare, which saw hospitals and other care organizations becoming more business-like with corporate governance structures, management hierarchies and growing levels of financial and operational independence. Even in care systems typically associated with predominately public funding, such as the English National Health Service (NHS), there is growing evidence that public hospitals derive a growing proportion of their income from commercial activities (Exworthy et al., 2023).

An extensive literature describes the challenge of management (as an ideology) and managers (as an occupation) to the dominant interests of medical professionalism and the clinical autonomy of doctors in the social organization of healthcare (Alford, 1975; Harrison et al., 1992; Waring & Currie, 2009). In short, the transition from hospital 'administration' to 'management' saw a corresponding displacement of professionals in the governance of care organizations. And yet, by the late 1980s and into the 1990s, researchers were describing a new or extended role for doctors and nurses within the maturing management structures of modern healthcare (Freidson, 1985; Coburn et al., 1997). Over time, this trend has deepened with healthcare professionals holding designated management or leadership roles across almost all tiers and domains of service organization, from clinical team leader through to the hospital medical director. Now

we are seeing even more elevated roles for elite doctors in the governance of care systems (Waring et al., 2020). Of particular interest to Kirkpatrick and colleagues is the role of medical doctors at the most senior levels of hospital governance.

In the wider social science literature, these clinical leadership roles are often discussed with reference to broader debates on the rise and spread of professional–managerial 'hybrids'. This has developed along at least four lines:

- The first considers the emergence of hybrid roles in the context of broader institutional changes (Noordegraaf, 2015), especially changing political and corporate agendas that combine professional, market and bureaucratic logics in the organization of expert work (Reay & Hinings, 2009).
- The second analyses how hybrids represent new expressions of power and authority in the organization of expert work, especially where corporate interests are manifest *through* professional leadership roles, rather than *over* professional work by managers (Numerato et al., 2011; Waring, 2014; Waring & Bishop, 2013).
- The third examines how those who hold these managerial roles develop distinct and sometimes liminal identities as a result of their precarious position at the interface of their professional and managerial peers (Bresnen et al., 2018; Croft et al., 2015; McGivern et al., 2015).
- The fourth shows how professional hybrids can support the development and implementation of strategic change through representing the voices of clinicians, enriching management decision-making and engaging clinicians in change processes (Burgess & Currie, 2013).

Present: the contribution of clinicians to senior management

Kirkpatrick and colleagues have firmly demonstrated the strategic contribution of medical leaders to healthcare governance. Through the analysis of multiple large-scale data sets they have been able to show how the increased involvement of doctors in senior hospital management, specifically hospital management boards, is statistically associated with improved organizational performance. With regards to care quality and patient experience, they have previously found a positive association between the percentage of doctors on senior management boards and the quality ratings given to care providers by national regulatory agencies (Veronesi et al., 2015, 2013a). In terms of financial performance, they have similarly found that hospitals with clinically-qualified managers appear to have better ratings for financial management (Veronesi et al., 2013b). They have also considered alternative lines of interpretation by analysing whether senior managers with business expertise can positively influence organizational performance, to which they find some evidence of effect for financial performance but no effect on care quality (Kirkpatrick et al., 2017).

Despite mounting policy and professional endorsement for more professional leadership in healthcare governance, there remain sceptical voices. Some of these more critical commentaries are, arguably, from an earlier time when medical leadership roles were new or tied to particular policy reforms. Some argue that the evidence for the impact of doctors on hospital performance remains under-developed (Clay-Williams et al., 2017). A major problem is the quality of evidence and analysis, especially the reliance on relatively small or single source data-sets. It is within this context that Kirkpatrick et al. (2023) position their recent article. With regards to the substantive issue, their article asks whether a greater critical mass of doctors in senior management teams leads to improved organizational performance. And with regards to the methodological issues, they draw upon and analyse multiple sources of routinely collected administrative data, focusing in particular on patient experience (satisfaction) scores for each NHS trust taken from the *NHS Adult Inpatient Survey*, and also hospital infection rates, with the data accumulated from a five-year period. For the authors, a key contribution of the article is the methodological and analytical rigour of their study that counters those who have called into question past research—thereby providing greater empirical confidence to the argument that medical involvement in hospital governance improves organizational performance. Empirically, the article shows that greater representation and involvement of medical professionals in senior management, in terms of a critical mass, is also positively associated with organizational performance in key markers of care quality.

So why is Kirkpatrick et al.'s PMM article so important? For me, the key learning is that a critical mass of medical involvement in senior management is beneficial to the governance of care services. Taking the long view, it might be argued that the institutionalization of corporate structures and ascendence of managerialism in the governance of healthcare services led to a corresponding marginalization of clinical involvement, insight and influence. For policy-makers in the mid 1980s, clinical involvement in hospital committee structures was viewed as excessively bureaucratic and as reinforcing the interests of professions to the neglect of service users and taxpayers (Waring, 2013). Although doctors and nurses acquired formal board-level positions in the evolving corporate structures of NHS trusts, it seems that such individual roles might not always be sufficient to provide the necessary clinical insight and analysis into senior-level decision-making. Kirkpatrick et al.'s (2023) study suggests that hospital boards (or senior management in general) need more and, arguably, more varied clinicians re-inserted into their membership, routines and procedures. To elaborate this idea, it is conceivable that a lone or small minority of clinical voices will be less heard by a more dominant managerial collective whose 'group think' has become fixated with corporate strategy, meeting government targets or assuring public reputation. It is also conceivable that, over time, a small minority of relatively permanent clinical leaders may come to share the corporate interests of managers (Waring & Bishop, 2013) and refrain from asking the difficult or uncomfortable questions about care standards that boards need to hear.

Might such possibilities be at play in recent high-profile scandals in which senior hospital managers consistently failed to hear and respond to the warning signs of malicious behaviours (Dyer, 2023)? With growing calls for managers to face greater scrutiny in their behaviour and

standards, perhaps the lens should be widened beyond the role of individual executives to consider the broader governance apparatus, especially the constitution and function of boards (Millar et al., 2013). This should include special consideration to the volume and variety of clinical involvement, and the processes of collective decision-making and accountability? This might include a greater portion of executives with clinical backgrounds or the creation of new checks-and-balance to the corporate executive in the form of clinical (and also patient) councils?

Future: new directions for research and policy?

Kirkpatrick et al.'s PMM article provides a springboard for future research and I offer a number of tentative lines for future enquiry. The first deals with the need to look beyond doctors and to recognize the important role played by other clinical professionals in senior management (Kelly et al., 2023). As noted by Kirkpatrick et al. (2023), nurses and other allied health professionals can bring important insight into decision-making and this can be equally important in countering the views of both management *and* medicine to ensure more inclusive and diverse perspectives inform governance activities. This might involve similar statistical research looking at the profile of different healthcare professionals in senior management and the associations with organization performance. And if the evidence is less strong, research might then consider why and how these other perspectives are not equally heard or influential?

A second area for future enquiry develops the idea that a critical mass of medical (or, rather, clinical) voices is beneficial to healthcare governance, which leads to the suggestion that more research is warranted on what might be the optimal configuration and profile of healthcare professionals in senior leadership and board-level roles. Depending on the type of healthcare organization, this could include profiling and comparing clinical specialities, the past experience of individuals, levels of clinical and management training, and also taking into account other important aspects of socio-cultural diversity, ethnicity, gender and age. If more clinical voices are beneficial, what configuration should policy-makers be working towards?

A third area of research might look further at what clinical leaders actually do in senior management roles to positively influence and enrich governance activities. Here, insight can be drawn from Jones and Fulop's (2021) recent study of medical directors which shows how these doctors carry out different types of work to enhance to absorptive capacity of organizations to identify and assimilate relevant information into decision-making processes. This includes 'translation work' to bring meaningful insight and intelligence into board activities, 'diplomatic work' to manage the competing agendas of professionals and managers, and 'repair work' to smooth over the tensions between stakeholders. Building on these ideas, we might further ask about the *collective work* of groups of healthcare professionals in senior management roles, such as how different professionals come together to find common agendas, how their diverse perspectives offer unique sources of learning, and how, when and why they unite as a collective to counteract management?

A fourth area of research might look more closely at the management culture of healthcare organizations to understand why some senior management groups are more inclusive of and receptive to the involvement of healthcare professionals. Do these organizations have a particular history, are they integrated into broader networks of healthcare governance, or are they characterised by particular specialist services that require closer involvement of clinical specialists in management decision-making? In short, what is it that makes some organizations more receptive than others to clinical involvement in senior management?

Finally, the fifth area for further research asks how Kirkpatrick et al.'s (2023) findings might be transferred to other healthcare organizations and levels of health system governance. This might include, for example, more focus on primary or community care service where the contexts, structures and processes of governance might be different to acute hospitals? A related line of research might be to look for areas of health service governance where medical and other healthcare professionals have traditionally had a fuller and more influential role in organizational governance, such as in primary care networks, to understand whether and how variations in medical leadership relate to organizational performance. In recent years, there has been growing emphasis on the region as an overarching platform for integration and improvement, specifically with the introduction of integrated care systems in the English health and care system. New supra-organizational levels of governance have been introduced —Integrated Care Boards—and there is growing evidence the clinical leaders can also play a key role in these new collaborative governance arrangements (Jones et al., 2022; Waring et al., 2023). The question further posed by Kirkpatrick et al.'s (2023) work is how might the volume and variety of clinical leaders in health system governance contribute to system-wide performance?

Concluding comments

In conclusion, a growing body of research clearly demonstrates the critical role clinical leaders, especially doctors, can play in healthcare governance. As policy-makers again ask questions about the effectiveness of existing NHS governance arrangements, especially the capacity of senior managers to detect the signs of unsafe care and to appropriately safeguard standards, careful consideration should be given to how best clinical insight can be integrated more routinely and fully into management decision-making. This might involve thinking differently about the configuration and profile of boards, and finding additional checks and balances that ensure management decision-making is more transparent and open to critical challenge, especially from clinicians and service users.

Disclosure statement

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