**The British Psychological Society**
**Division of Occupational Psychology Annual Conference 2008**

# Involving Doctors in Management: Key Concepts and Challenges for today's NHS

Simon Moralee and Steven Lyttle, De Montfort University

## Summary

The present study was carried out within a theoretical framework of personal construct systems (Kelly 1955) and drew out views from clinicians on their motivation to become involved in the NHS management agenda, especially with regard to their future training requirements and desire for involvement. The aim of future research would be to focus in further on the 'interests and career' elements and draw out a more informed psychological profile of clinician involvement in management.

## Objective

The objective of this study was to focus on UK clinicians' own perspectives on (non-) engagement in management at a time when the NHS was in a period of organisational and management change.

## Design

The study was both qualitative and quantitative in construction. It applied personal construct theory so that the selected participants' views on management could be drawn out, rather than any potential biased views that the researcher/interviewer might hold. Semi-structured interviews with five clinicians currently involved at a senior manager level were held to create a survey that was subsequently sent to 80 consultants within an NHS organisation (see Appendix A for details) to elicit their views using a Likert scale.

## Methods

The study was undertaken between November 2004 and March 2005. Primary data were collected from two sources: Five face-to-face interviews (see Appendix B for details) with clinicians deemed by their roles to already be involved in management at a senior level in the organisation, and through a postal survey containing questions derived from the interviews, sent to 80 NHS consultants.

The study was carried out within a theoretical framework of personal construct systems developed by George Kelly, a social psychologist in the USA in the 1950s, (Kelly 1955) as a paradigm for exploring the ways in which individuals interpret and make sense of their intrapersonal and interpersonal worlds.

Eliciting an account of people's key constructs allows the researcher "to stand in others' shoes, to see their world as they see it, and to understand their situation and their concerns." (Fransella, Bell & Bannister 2004, p.6) Personal construct theory suggests that all people create and re-create an implicit theoretical framework that informs behaviour.

Constructs are theorised to be bipolar. Thus, when an individual affirms his/her views on one issue, he/she is simultaneously saying whatever the opposite or difference is, however, this opposite or difference is self-constructed. In affirming his or her views, the individual offers up an emergent pole, which also means that he/she offers up a so-called implicit pole which can be elicited through the research process.

**Analysis of Data**

There are a number of ways that the data can be analysed, following the application of Repertory Grid, from a simple average of scores, to more specific manual or web-based Repertory Grid techniques of analysis. All offer some form of correlation, which allow both likenesses from the data and interpretations regarding the strength of relationships to be drawn. The results can be seen presented below.

5 consultants were interviewed, all of whom were male. Three were in the age range 55-59, one in the range 45-49 and one in the range 40-44. They had between 21 and 32 years experience as a doctor (with a mean of 28 years), between 10 and 24 years experience as a consultant (with a mean of 17 years) and had been at lead clinician/head of service level or above for between 4 and 13 years (with a mean of 10 years).

Their views ('constructs') on the 23 themes ('elements') (see Appendices C & D) led to the creation of a survey ('Repertory Grid'), which was sent to 77 consultants at UHL (see Appendix E). One of these was a duplication, an error on behalf of the researcher and was thus excluded from the list. Of the 76 sent, 55 were sent to male consultants and 21 to female consultants.

15 consultants (19%) responded to the survey, of whom 11 were male and 4 female (see Appendix F for details of their clinical specialties). 17 consultants (22%) declined to take part and 40 (53%) had not responded to either the initial survey or follow-up telephone call. Five surveys (7%) were returned indicating that the consultant had either left the organisation or retired.

The gender of respondents was as follows:

| **Gender** | Surveys sent | Responded to | Declined, not responded, other |
|---|---|---|---|
| Male | 55 | 11 (20%) | 44 |
| Female | 21 | 4 (19%) | 17 |
| Total | 76 | 15 (20%) | 61 |

Their age range, directorate, length of service and hospital site are indicated in the following tables. Whilst male consultants who responded spanned ages from 35 to 60+, of the four female consultants to reply the age range spanned 50 to 59 years.

| **Age and gender** | Male – responded to | Female – responded to |
|---|---|---|
| 30-34 | 0 | 0 |
| 35-39 | 2 | 0 |
| 40-44 | 1 | 0 |
| 45-49 | 4 | 0 |

| | | |
|---|---|---|
| 50-54 | 1 | 2 |
| 55-59 | 2 | 2 |
| 60+ | 1 | 0 |
| Total | 11 | 4 |

All respondents had been doctors between 13 and 34 years with the average for male consultants of 23 years and for female consultants of 30 years. The average length of time as a consultant was 13 years for male respondents and 16 for female respondents.

| **Length of Service (average years)** | Male – responded to | Female – responded to |
|---|---|---|
| Doctor | 23 | 30 |
| Consultant | 13 | 16 |
| Lead Clinician | 5 | 7 |

Of the 12 clinical directorates, representatives from eleven were sent surveys, as Clinical Support Services is made up of Allied Health Professional (AHPs) staff. Of the fifteen responses, three (20%) came from A&E and Medicine, 3 (20%) from Anaesthetics, Critical Care and Pain Management, 4 (27%) from the Surgical directorate and the remaining five (33%) from five other directorates. There were no responses from three directorates (Cardio-Respiratory, Children's and Women's, Perinatal and Sexual Health).

| **Directorate** | Surveys sent | Responded to | Declined, not responded, other |
|---|---|---|---|
| A&E and Medicine* | 12 | 3 (25%) | 9 |
| Anaes, CC and PM | 14 | 3 (21%) | 11 |
| Cancer & Haematology | 4 | 1 (25%) | 3 |
| Cardio-Respiratory | 7 | 0 (0%) | 7 |
| Children's | 5 | 0 (0%) | 5 |
| Imaging | 7 | 1 (14%) | 6 |
| Musculo-Skeletal | 7 | 1 (14%) | 7 |
| Pathology | 5 | 1 (14%) | 4 |
| Renal & Urology | 3 | 1 (14%) | 2 |
| Surgical | 8 | 4 (50%) | 4 |
| Women's, Perinatal & SH | 4 | 0 (0%) | 4 |
| **Total** | 76 | 15 (20%) | 61 |

*This includes one consultant who works within the Human Resources (corporate) directorate.

Thirty-five surveys (46%) were sent to consultants at the Leicester Royal Infirmary site, 21 (28%) to Leicester General Hospital consultants and 20 (26%) to Glenfield Hospital consultants. Seven (47%) of the fifteen responses came from LRI, with five (33%) from Leicester General and three (20%) from Glenfield Hospital.

| **Site** | Surveys sent | Responded to | Declined, not responded, other |
|---|---|---|---|
| LRI | 35 | 7 | 28 |
| LGH | 21 | 5 | 16 |
| GH | 20 | 3 | 17 |
| **Total** | 76 | 15 | 61 |

In addition, from the survey responses, a simple *mode* average could be determined. In the table below, the *italics* indicate a preference from respondents towards a particular pole.

| | ELEMENTS | EXPLICIT POLE (= 1 to 3) | Mode | IMPLICIT POLE (= 4 to 6) |
|---|---|---|---|---|
| 1 | **Leadership** | *Good communication* | 2 | Telling people what to do |
| 2 | **Financial Resources** | *Inadequate and constrained* | 2 | Is about discipline and creativity |
| 3 | **Management-specific education/training for doctors** | *Necessary and highly desirable* | 2 | Poorly undertaken and inadequate |
| 4 | **UHL managers** | Interested (in the service) and successful professionals | 5 | *Divorced from the "coalface" with a focus on the bottom line* |
| 5 | **UHL "top team" i.e. Director level** | Strong, hard working and successful | 4 | *Not visible and reading the national priorities wrong* |
| 6 | **Directorate management** | *"Silo" management* | 2 | Gets the job done |
| 7 | **Management meetings** | *Too many, administrative and tedious* | 2 | Focussed, effective and democratic |
| 8 | **Clinical audit** | *Poorly defined with a "tick-box" approach* | 1 | Targeted, useful and measurable |
| 9 | **Clinical Director role** | Crucial and defines the vision | 4 | *Necessary to manage other doctors* |
| 10 | **Clinical Directorate model** | Gets clinician buy-in | 4 | *Creates unnatural alliances* |
| 11 | **Staff open forums** | *A good concept* | 3 | Unconvincing, not successful nor well attended |
| 12 | **Star ratings** | Have set strategy and improved care | 6 | *Wrong focus and micromanagement* |
| 13 | **Management as a career for doctors** | *Haphazard with no clear progression* | 2 | Able to make more of a difference |
| 14 | **Change** | *A welcome part of everyday work* | 2 | Is imposed and creates resistance |
| 15 | **Management of clinical colleagues** | *Difficult* | 3 | Enjoyable because they are passionate about what they do |
| 16 | **Your role in this organisation** | *Enjoyable, motivating and exciting* | 2 | Futile, with uncertainty and lack of control |
| 17 | **The multi-disciplinary team you're part of, i.e. those you work with on a daily basis** | *Equal and coordinated, with a clear structure* | 1 | Divergent, egotistical and no clear purpose |

| | | | | |
|---|---|---|---|---|
| 18 | **Conflict** | *Is about understanding different views* | 2 | Inevitable, uncomfortable and not easy to deal with |
| 19 | **Private practice** | *Personal financial gain* | 3 | Perverse incentive that creates a differing relationship with patients |
| 20 | **"Pathway"** | *Unwieldy, expensive and uncertain* | 2 | Transform health care in Leicester, in new buildings |
| 21 | **Your manager** | *Honest, effective and supportive* | 2 | Unclear, controlling and remote |
| 22 | **Your organisation in three years time** | Redesigned services in a more competitive environment | 5 | *In transition (a building site) but much the same* |
| 23 | **Strategy** | *Centrally (government) driven* | 1 | Being realistic with the "vision" |

This form of average was chosen as it represented the most common value amongst respondents who demonstrated strong preferences in terms of clinical audit, describing it as "poorly defined with a 'tick-box' approach"; the teams they worked with on a daily basis, which were described as equal and coordinated with a clear structure; star ratings, which were deemed to have the wrong focus and be about micromanagement; and strategy, which was seen to be centrally-driven.

Less strong preference was shown for a number of other factors, such as leadership, financial resources and management education for doctors, which were respectively described as being about good communication, inadequate and constrained and necessary and highly desirable. There were slight preferences shown for the remaining five factors, including the role of the clinical director and the clinical directorate model as well as staff open forums, management of clinical colleagues and private practice.

The data was analysed using *WebGrid III*[1], which allowed the researcher to enter the Likert-scale preferences (from 1 to 6 in this case) into a model that produces two key analyses.

The first is known as *principal component analysis*, which positions each element on a map, so that ones which are similar are close to one another. Principal component analysis does involve a mathematical procedure that transforms a number of (possibly) correlated variables into a (smaller) number of uncorrelated variables called principal components, with the purpose being to identify new meaningful underlying variables.

The second form of analysis allows for a form of cluster analysis to be performed, called *dendritic analysis*, which re-sorts 'elements' and 'constructs' with the aim being to reveal further meanings behind groups of similar data. The idea of revealing the meanings in a Grid by re-sorting it is to place like elements together and like constructs together. Furthermore, alongside the Grid, a set of 'trees' are drawn, which show the strength of any existing correlations.

[1] *WebGrid III* is an internet-based 'freeware' programme and can be found at http://tiger.cpsc.ucalgary.ca/

In this research, dendritic analysis was chosen as the preferred form of analysis, as it loses none of the detail of the relationships between elements and/or constructs, whilst principal component analysis does, although it offers an easier-to-understand visual demonstration of the relationships between elements and constructs.

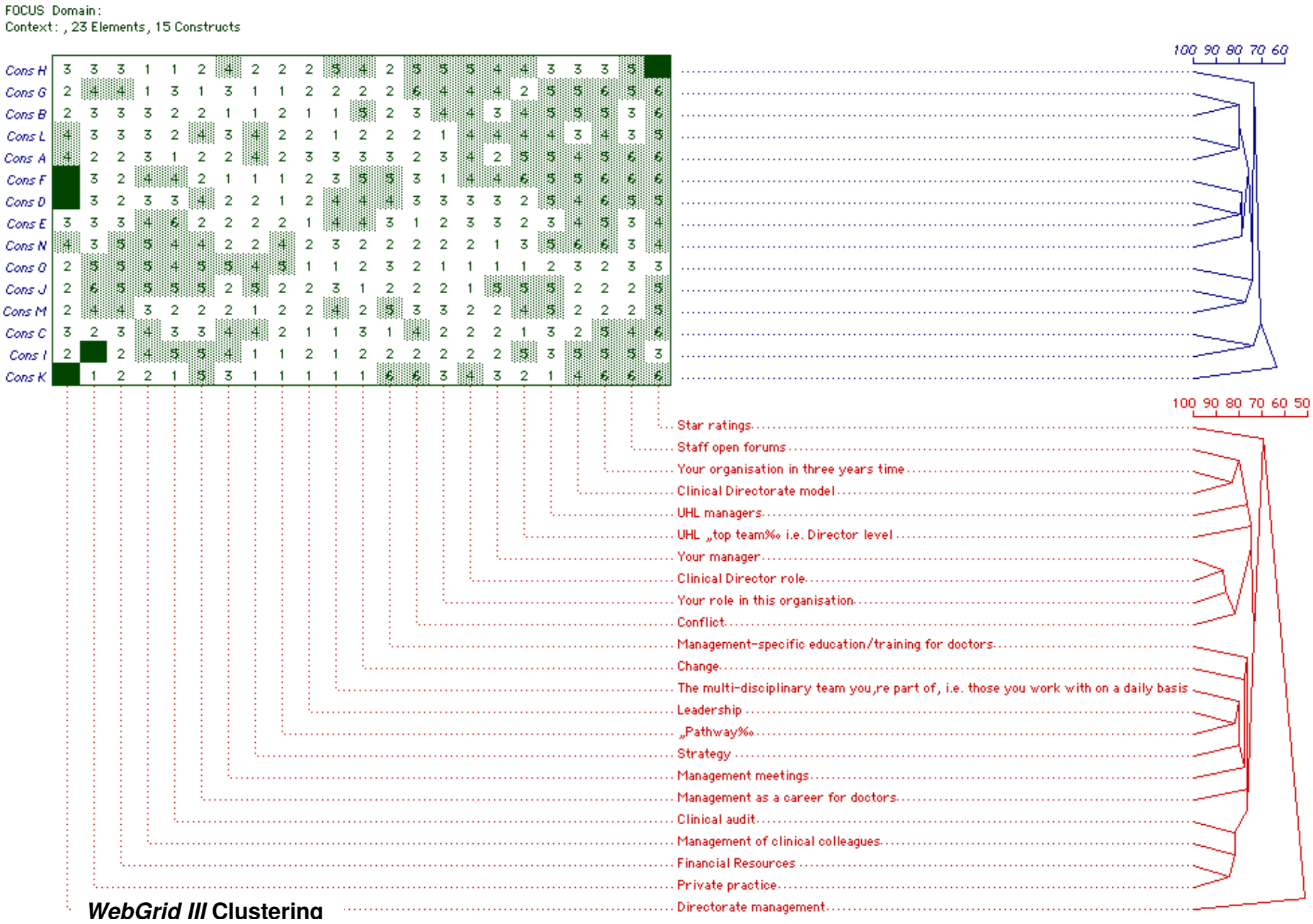
In ‘classic’ Grid theory, the results from dendritic analysis can be interpreted and further questions asked of interviewees to verify that two closely-aligned elements actually represent the truth of the situation or not. As this is not possible within the timeframe of this research, it will instead allow recommendations to be made for further areas of interest to be explored.

37 pairs of elements showed a correlation of .76 or higher but eight pairs had a higher correlation of above .80 between the elements. These are also shown below. Three elements did not show a correlation with any other element of greater than .76: these were E5 (UHL top team), E6 (Directorate management) and E12 (Star ratings).

## *WebGrid III* Element Correlation

| Corr. | Element | Element |
|---|---|---|
| .87 | E9 (Clinical Director role) | E21 (your manager) |
| .85 | E9 (Clinical Director role) | E16 (Your role in this organisation) |
| .84 | E2 (Financial resources) | E19 (Private practice) |
| .83 | E10 (Clinical directorate model) | E22 (Your organisation in 3 years time) |
| .81 | E1 (Leadership) | E20 (“Pathway”) |
| .81 | E2 (Financial resources) | E15 (Management of clinical colleagues) |
| .81 | E8 (Clinical audit) | E15 (Management of clinical colleagues) |
| .81 | E16 (Your role in this organisation) | E18 (Conflict) |
| .80 | E1 (Leadership) | E17 (The MDT you’re part of) |
| .80 | E9 (Clinical Director role) | E14 (Change) |
| .80 | E11 (Staff open forums) | E22 (Your organisation in 3 years time) |
| .80 | E16 (Your role in this organisation) | E21 (Your manager) |
| .80 | E20 (“Pathway”) | E23 (Strategy) |
| .79 | E10 (Clinical directorate model) | E11 (Staff open forums) |
| .79 | E1 (Leadership) | E16 (Your role in this organisation) |
| .79 | E7 (Management meetings) | E20 (“Pathway”) |
| .79 | E13 (Management as a career) | E15 (Management of clinical colleagues) |
| .77 | E1 (Leadership) | E23 (Strategy) |
| .77 | E2 (Financial resources) | E21 (your manager) |
| .77 | E7 (Management meetings) | E23 (Strategy) |
| .77 | E9 (Clinical Director role) | E18 (Conflict) |
| .77 | E14 (Change) | E17 (The MDT you’re part of) |
| .77 | E16 (Your role in this organisation) | E17 (The MDT you’re part of) |
| .76 | E1 (Leadership) | E3 (Management-specific education) |
| .76 | E1 (Leadership) | E7 (Management meetings) |
| .76 | E1 (Leadership) | E14 (Change) |
| .76 | E2 (Financial resources) | E7 (Management meetings) |
| .76 | E2 (Financial resources) | E13 (Management as a career) |
| .76 | E2 (Financial resources) | E20 (“Pathway”) |
| .76 | E3 (Management-specific education) | E14 (Change) |
| .76 | E4 (UHL managers) | E10 (Clinical directorate model) |
| .76 | E7 (Management meetings) | E13 (Management as a career) |
| .76 | E7 (Management meetings) | E16 (Your role in this organisation) |
| .76 | E8 (Clinical audit) | E13 (Management as a career) |
| .76 | E9 (Clinical Director role) | E10 (Clinical directorate model) |
| .76 | E13 (Management as a career) | E20 (“Pathway”) |
| .76 | E14 (Change) | E16 (Your role in this organisation) |

# The British Psychological Society
# Division of Occupational Psychology Annual Conference 2008



## Results

The literature indicated a number of reasons for clinical (non-) engagement in management. Evidence suggested that doctors believe they should be involved in management decisions (Balderson & MacFadyen 1994) and are 'natural managers' (Bruce & Hill, 1994), as well as being best placed to make resource decisions (Burrows, 1994), given their unique and valuable understanding of health care (Fitzgerald 1994), It also suggests that doctors not only become involved in management as a defence mechanism (Ong, Boaden and Cropper 1997) but also because they have a moral and ethical responsibility to be involved (Chantler 1999).

Conversely, there is a view that doctors may have a problem understanding management (Marnoch 1996, Sutherst & Glascott 1993) are unclear about the expectations of their role (Bruce & Hill 1994, Willcocks 1998), and do not see a notable career path for themselves in management (Austin & Dopson 1997, Fitzgerald 1994).

There is also evidence that some find management decisions difficult, for example, in terms of understanding and then employing management terminology (Fitzgerald 1994). In addition, they cite lack of time (Burrows 1994, Balderson & MacFadyen 1994, Corbridge 1995, Fitzgerald 1994) and a lack of support and training (Horsley, Roberts, Barwick, Barrow & Allen 1996, Austin & Dopson 1997) as reasons for not engaging, as well as their distrust that managers represent and enforce political will (Buchanan, Jordan, Preston & Smith 1997, McClelland & Jones 1997), with some going as far as saying that clinicians and managers inhabit different worlds (Dopson 1994, Scott 2000, Walker & Morgan 1996).

Data analyses supported a number of these themes and revealed a desire from clinicians for non-clinical managers to get a better understanding of the clinical viewpoint and a need for further national benchmarking in terms of audit in order to make it more meaningful. There was evidence to support the notion that clinicians enjoyed multi-disciplinary team working and that they were willing to offer the organisation their views regarding its structure in the belief that their knowledge and skills could be of benefit.

## Conclusion

The focus of this approach was on five areas: skills and standards; interest and career; role pressure/time; clinical conflict; and resource management and organisation. Of these, 'interest and career' focused most on the motivational factors around clinical involvement and there was real willingness from respondents to involve themselves further in management roles, although with questions about how they could be supported to do this. In addition, there were questions raised over whether their role should be a management one or more focussed towards leadership.

Future research would aim to cover areas such as whether management can ever be a credible career for doctors; what are the biggest influences on clinician willingness and ability to get involved in management; what new challenges are doctors seeking in their careers; how can it be explained that whilst so many doctors think it is important they are involved in management, very few report any personal involvement themselves;

and, what are the main sources of satisfaction and dissatisfaction in clinicians' management roles.

**References**


1. ALLEN, D. "Doctors in management or the revenge of the conquered: The role of management development for doctors" *Journal of Management in Medicine*, 1995; 9: 44-50

2. AUSTIN, N. and DOPSON, S. (eds) *The Clinical Directorate*, Radcliffe, 1997

3. BALDERSON, S. and MacFADYEN, U. "Management Training for Doctors: An In-house Approach" *Journal of Management in Medicine*, 1994; 8: 17-19

4. BRUCE, A. and HILL, S. "Relationships between doctors and managers: The Scottish experience" *Journal of Management in Medicine*, 1994; 8: 49-57

5. BUCHANAN, D., JORDAN, S., PRESTON, D. and SMITH, A. "Doctor in the process: The engagement of clinical directors in hospital management" *Journal of Management in Medicine*, 1997; 11: 132-56

6. CHANTLER, C. "National Health Service: The role and education of doctors in the delivery of health care" *The Lancet*, 1999; 353: 1178-81

7. CORBRIDGE, C. "Pandora's Box: clinical directorates and the NHS" *Journal of Management in Medicine*, 1995; 9: 16-20

8. CURLEY, A., McCLURE, G., SPENCE, D. and CRAIG, S. "The new NHS: modern, definable? A questionnaire to assess knowledge of, and attitudes to, the new NHS" *Clinician in Management*, 2002; 11: 15-23

9. DEPARTMENT OF HEALTH AND SOCIAL SECURITY *Griffiths Report, NHS Management Inquiry Report*, London, 1983

10. DEPARTMENT OF HEALTH *Working for Patients* HMSO, London, 1989

11. DEPARTMENT OF HEALTH *The NHS Plan: A plan for reform, a plan for investment* The Stationery Office, Norwich, 2000

12. DOPSON, S. "Management: The One Disease Consultants Did Not Think Existed" *Journal of Management in Medicine*, 1994; 8: 25-36

13. FITZGERALD, L. "Moving Clinicians into Management: A Professional Challenge or Threat?" *Journal of Management in Medicine*, 1994; 8: 32-44

14. FRANSELLA, F., BELL, R. and BANNISTER, D. *A Manual for Repertory Grid Technique* Second Edition, John Wiley and Sons, 2004

15. GAINES, B. R. and SHAW, M. L. G. *WebGrid III* [online] Calgary, Canada, University of Calgary, 2005. Available from: http://tiger.cpsc.ucalgary.ca/ [Accessed 30 March 2005]

16. GATRELL, J. and WHITE, T. “Doctors and management – the development dilemma” *Journal of Management in Medicine*, 1996; 10: 6-12

17. HEALTH SERVICE JOURNAL. *The making of a medical director* Volume 114, No. 5910 EMAP Publications, 17 June 2004

18. HOFFENBURG, R. *Clinical Freedom*, Nuffield Provincial Hospitals Trust, London, 1987

19. HOPKINSON, R.B. “Clinical Leadership in Practice – Wearing Many Hats” *Health Care and Informatics Review Online*, 2000; 4 (9)

20. HORSLEY, S., ROBERTS, E., BARWICK, D., BARROW, S. and ALLEN, D. “Recent trends, future needs: management training for consultants” *Journal of Management in Medicine*, 1996; 10: 47-53

21. MARNOCH, G. *Doctors and Management in the NHS*, Open University Press, 1996

22. MATHIE, A.Z. “Doctors and change” *Journal of Management in Medicine*, 1997; 11: 342-56

23. McCLELLAND, S. and JONES, K. “Management education for undergraduate doctors: A survey of medical schools” *Journal of Management in Medicine*, 1997; 11: 335-41

24. McDERMOTT, R., CALLANAN, I. and BUTTIMER, A. “Involving Irish clinicians in hospital management roles – towards a functional integration model” *Clinician in Management*, 2002; 11: 37-46

25. OFFICE FOR HEALTH MANAGEMENT. *Clinicians in Management: Introduction and Case Studies* Discussion Paper No. 1, 2000

26. OFFICE FOR HEALTH MANAGEMENT. *Clinicians in Management: A Review of Clinical Leadership* Discussion Paper No.4, 2003

27. ONG, B.N., BOADEN, M. and CROPPER, S. “Analysing the medicine-management interface in acute trusts” *Journal of Management in Medicine*, 1997; 11: 88-95

28. OWEN, A.V. “Management for Doctors: Getting the Best from People” *British Medical Journal*, 1995; 310: 648-51

29. PERKINS, R. “Leading Health Organisations in New Zealand – Part 1” *Health Care and Informatics Review Online*, 2004a

30. PERKINS, R. “Leading Health Organisations in New Zealand – Part 2” *Health Care and Informatics Review Online*, 2004b

31. BURROWS, M., DYSON, R., JACKSON, P. and SAXTON, H. (eds) *Management for hospital doctors* Oxford: Butterworth-Heinemann, 1994

32. SCOTT, T. “Clinicians in Management” *Health Care and Informatics Review Online*, 2000; 4 (2)

33. SIMPSON, J. “Clinical Leadership in the UK” *Health Care and Informatics Review Online*, 2000; 4 (2)

34. STEWART, V. *Business Applications of Repertory Grid* [online] Wellington, New Zealand, Enquire Within Developments Ltd, 2004. Available from: http://www.enquirewithin.co.nz/BUS_APP/business.htm [Accessed 30 March 2005]

35. SUTHERLAND, K. and DAWSON, S. “Power and quality improvement in the new NHS: the roles of doctors and management” *Quality in Health Care*, 1998; 7 (Suppl): S16-S23

36. SUTHERST, J. AND GLASCOTT, V. *The Doctor-Manager*, Churchill Livingstone, Longman, UK, 1993

37. WALKER, R. and MORGAN, P. “Involving doctors in management: A survey of the management development career needs of selected doctors in NHS Wales” *Journal of Management in Medicine*, 1996; 10: 31-52

38. WILLCOCKS, S. “The Clinical Director in the NHS: Utilizing a Role-theory Perspective” *Journal of Management in Medicine*, 1994; 8: 68-76

39. WILLCOCKS, S. “Managerial Effectiveness in the NHS: A possible framework for considering the effectiveness of the clinical director” *Journal of Management in Medicine*, 1997; 11: 181-89

40. WILLCOCKS, S. “The development of clinical management at an NHS Trust hospital: A case study example” *Journal of Management in Medicine*, 1998; 12: 168-77

## APPENDIX A: UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST (www.uhl-tr.nhs.uk)

University Hospitals of Leicester NHS Trust (UHL) is one of the largest and busiest teaching Trusts in England, employing over 11,000 staff and providing services to nearly a million people across Leicester, Leicestershire and Rutland. It has an annual income of £460 million. The Trust was formed on 1 April 2000, following the merger of Glenfield Hospital, Leicester General Hospital and Leicester Royal Infirmary. All three hospitals provide acute general hospital services to the people of Leicester, Leicestershire and Rutland.

The Trust also provides high-quality specialist care, including cardiovascular, cancer, fertility and renal services to patients across the country, with many being referred by other hospital consultants. Locally, the Trust serves, in partnership with 6 Primary Care Trusts, a diverse area of contrast, with some of the poorest communities in the country alongside some of the wealthiest. In 2000, the Trust embarked on the *Pathway* project, a private-finance initiative plan to reconfigure acute services in Leicester, Leicestershire and Rutland.

There are 12 Clinical and 10 Corporate directorates within UHL (as of May 2005), as listed below:

**Clinical**

1. A&E and Medicine Services
2. Anaesthetics, Critical Care & Pain Management
3. Cancer & Haematology Services
4. Cardiology Respiratory Services
5. Children's Services
6. Clinical Support Services (includes Disablement Services Centre, Medical Illustration, Medical Psychology, Neuro Psychology, Nutrition and Dietetics, Occupational Therapy, Orthotics, Pharmacy Department, Phlebotomy, Physiotherapy Department, Podiatry, Speech and Language Therapy)
7. Imaging
8. Musculo-Skeletal Services
9. Pathology Services
10. Renal Services & Urology
11. Surgical Services
12. Women's, Perinatal & Sexual Health Services

**Corporate**

1. Clinical Governance
2. Corporate & Legal Affairs
3. Facilities
4. Finance
5. Human Resources
6. Information Management & Technology
7. Nursing
8. Operations
9. Research & Development
10. Strategic Development

**APPENDIX B: INTERVIEW PROFORMA: Elements and Constructs**

"What things come to mind when you think about…"

| Emergent Pole | Element | Implicit Pole |
|---|---|---|
| | Leadership | |
| | Financial Resources | |
| | Management-specific education/training | |
| | UHL managers | |
| | UHL "top team" | |
| | Directorate management | |
| | Management meetings | |
| | Audit | |
| | Clinical Director role | |
| | Clinical Directorate model | |
| | Staff open forums | |
| | Star ratings | |
| | Management as a career | |
| | Change | |
| | Management of clinical colleagues | |
| | Your role | |
| | The multi-disciplinary team you're part of | |
| | Conflict | |
| | Private practice | |
| | "Pathway" | |
| | Your manager | |
| | Your organisation in three years time | |
| | Strategy | |

**Demographic questions**

Gender: M F

Age Range: 30-34 35-39 40-44 45-49 50-54

55-59 60+

Length of Service (years) as:

- Doctor……
- Consultant ……
- Clinical/Other Director……

**Name (optional)……**

## APPENDIX C: ELEMENTS

1. Leadership
2. Financial Resources
3. Management-specific education/training for doctors
4. UHL managers
5. UHL "top team" i.e. Director level
6. Directorate management
7. Management meetings
8. Clinical audit
9. Clinical Director role
10. Clinical Directorate model
11. Staff open forums
12. Star ratings
13. Management as a career for doctors
14. Change
15. Management of clinical colleagues
16. Your role in this organisation
17. The multi-disciplinary team you're part of, i.e. those you work with on a daily basis
18. Conflict
19. Private practice
20. "Pathway"
21. Your manager
22. Your organisation in three years time
23. Strategy

## APPENDIX D: RESEARCH AREAS

The researcher was able to find forty questions regularly emerging from the literature that have been used in the past to ask doctors about their involvement in management. These naturally fall into five thematic groups. The questions and their groupings are outlined below. Out of these questions came the 23 'elements' used in the Repertory Grid interviews. The forty questions would fit well into a traditional questionnaire but this research model was keen to eliminate as much bias as possible from the process and instead allow doctors the freedom to express, in their own words, their views on management. The 23 elements that were chosen were relevant to the local environment of the study and consultants would have been aware of their existence.

*SKILLS and STANDARDS*

1 - Can a doctor be a strategist / influencer?
2 – What is the value of professional management standards?
7 - Would you like management training to be a part of your job?
10 - What particular skills would be of value? E.g. finance, HR, communications, time management, conflict management, change management, contextual awareness?
13 – Is involvement in management 'de-professionalising'?
16 - What are your views on leadership? What does it take to be a leader?
19 - Are doctors' natural managers?
28 - Would you have benefited from some management training / development at medical school, given what you know and experience now?
34 - What benefits do you think a clinical education can bring to the process of management and delivering health care services?
40 - What do you consider to be the key factors in creating a successful management role / being a successful manager?

*INTEREST and CAREER*

3 - Can management ever be a career for doctors?
4 – What is your approach or feeling towards innovation (as expressed by Rogers (1962) innovator to laggard model)?
5 - What is the biggest influence on your willingness and ability to get involved in management?
6 - What areas of management would you like to be involved in?
14 - What new challenges are you seeking in your career?
15 - Can management be "credible" to doctors?
22 - Could doctors simply be very expensive and inexperienced managers?
25 - Can you explain why so many doctors think it is important doctors are involved in management; yet report no personal involvement themselves?
30 - What would you say is the single most important reason for involving doctors in management?
35 - What are your main sources of satisfaction and dissatisfaction in your role?
36 - What advice would you offer about management in the NHS to a doctor about to become a consultant?
38 - Is a management role a "career break" or rather a stepping-stone for the future?

*ROLE PRESSURE / TIME*

8 - Are you put off actively involving yourself in management in the NHS because it will impinge on clinical activities within as well as outside the NHS?
9 – Does involvement in management create 'role overload'?

*(CLINICAL) CONFLICT*

11 - Is your involvement in management eroding your clinical autonomy / authority?
17 - Do you fear being managed and does that influence whether you get involved in management activities or not?
18 - What is your opinion of current non-medical managers and their ability to run the NHS?
21 - Should managers be able to challenge the decision making of doctors?
23 - Would you rather maintain clinical credibility as a consultant at the expense of achieving success as a manager of clinical resources?
26 - Do you fear being alienated from your peers by involving yourself in management activities?
27 - If doctors were to become more involved in management, do you think there would be reluctance amongst non-medical managers to let go of responsibility?
32 - Do you accept there is a managerial / management responsibility that accompanies your clinical freedom?
33 - Do you think the interests and priorities of managers and doctors are in conflict?
39 - Do you think clinical managers can ever effectively line manage their clinical colleagues?

*RESOURCE MANAGEMENT and ORGANISATION*

12 – Is your clinical decision-making ever influenced by rationing / economic constraints?
20 - What is the perception of your role and responsibility with regard to the management of resources?
24 - Is involving doctors in management an efficient and effective way of using resources?
29 - How relevant do you see the economic and practical constraints of the NHS in your every day decision-making?
31 - Do you see managers as part of the multi-disciplinary team that helps to deliver health care?
37 - How do you think your clinical directorate / department should be organised?

**APPENDIX D: SURVEY PROFORMA**

**Survey: Involving doctors in management**

Please indicate your preference for the "emergent" or "implicit" pole by circling only one appropriate number, where 1 = strongly agree with the emergent pole, 2 = slightly agree with emergent pole, 3 = agree with explicit pole, 4 = agree with implicit pole, 5 = slightly agree with implicit pole, 6 = strongly agree with implicit pole.

For example, for the theme **"oranges"**, the emergent pole is **"sweet"**, whilst the implicit pole is **"bitter."** If you strongly agree that oranges are sweet, circle the number "1", but if you agree oranges are bitter, circle the number "4" and so on.

| Theme | Emergent Pole | Scale | Implicit Pole |
|---|---|---|---|
| Oranges | Sweet | **1 2 3 4 5 6** | Bitter |

Please now indicate your preferences on the grid below:

| Theme | Emergent Pole | Scale | Implicit Pole |
|---|---|---|---|
| Leadership | Good communication | **1 2 3 4 5 6** | Telling people what to do |
| Financial Resources | Inadequate and constrained | **1 2 3 4 5 6** | Is about discipline and creativity |
| Management-specific education/training for doctors | Necessary and highly desirable | **1 2 3 4 5 6** | Poorly undertaken and inadequate |
| UHL managers | Interested (in the service) and successful professionals | **1 2 3 4 5 6** | Divorced from the "coalface" with a focus on the bottom line |
| UHL "top team" i.e. Director level | Strong, hard working and successful | **1 2 3 4 5 6** | Not visible and reading the national priorities wrong |
| Directorate management | "Silo" management | **1 2 3 4 5 6** | Gets the job done |

**The British Psychological Society**
**Division of Occupational Psychology Annual Conference 2008**

| | | | |
|---|---|---|---|
| Management meetings | Too many, administrative and tedious | **1 2 3 4 5 6** | Focussed, effective and democratic |
| Clinical audit | Poorly defined with a "tick-box" approach | **1 2 3 4 5 6** | Targeted, useful and measurable |
| Clinical Director role | Crucial and defines the vision | **1 2 3 4 5 6** | Necessary to manage other doctors |
| Clinical Directorate model | Gets clinician buy-in | **1 2 3 4 5 6** | Creates unnatural alliances |
| Staff open forums | A good concept | **1 2 3 4 5 6** | Unconvincing, not successful nor well attended |
| Star ratings | Have set strategy and improved care | **1 2 3 4 5 6** | Wrong focus and micromanagement |
| Management as a career for doctors | Haphazard with no clear progression | **1 2 3 4 5 6** | Able to make more of a difference |
| Change | A welcome part of everyday work | **1 2 3 4 5 6** | Is imposed and creates resistance |
| Management of clinical colleagues | Difficult | **1 2 3 4 5 6** | Enjoyable because they are passionate about what they do |
| Your role in this organisation | Enjoyable, motivating and exciting | **1 2 3 4 5 6** | Futile, with uncertainty and lack of control |
| The multi-disciplinary team you're part of, i.e. those you work with on a daily basis | Equal and coordinated, with a clear structure | **1 2 3 4 5 6** | Divergent, egotistical and no clear purpose |

**The British Psychological Society**
**Division of Occupational Psychology Annual Conference 2008**

| | | | |
|---|---|---|---|
| Conflict | Is about understanding different views | **1 2 3 4 5 6** | Inevitable, uncomfortable and not easy to deal with |
| Private practice | Personal financial gain | **1 2 3 4 5 6** | Perverse incentive that creates a differing relationship with patients |
| "Pathway" | Unwieldy, expensive and uncertain | **1 2 3 4 5 6** | Transform health care in Leicester, in new buildings |
| Your manager | Honest, effective and supportive | **1 2 3 4 5 6** | Unclear, controlling and remote |
| Your organisation in three years time | Redesigned services in a more competitive environment | **1 2 3 4 5 6** | In transition (a building site) but much the same |
| Strategy | Centrally (government) driven | **1 2 3 4 5 6** | Being realistic with the "vision" |

**Demographic questions**

Please indicate gender and age below:

**Gender**: Male Female **Age Range**: 30-34 35-39 40-44 45-49 50-54 55-59 60+

Please indicate your length of service (in years) for the following:

Doctor……Consultant ……Clinical/Other Director (e.g. Lead Clinician, Head of Service)…… ……

Name (optional)…….. ……. Directorate…….. ……

## APPENDIX F: Survey Respondents

| | |
|---|---|
| A | Consultant Dermatologist |
| B | Consultant Neurologist |
| C | Consultant Occupational Physician |
| D | Consultant Anaesthetist |
| E | Consultant Anaesthetist |
| F | Consultant Anaesthetist |
| G | Consultant Histopathologist |
| H | Consultant, Surgical Directorate |
| I | Consultant Surgeon |
| J | Consultant Vascular Surgeon |
| K | Consultant Surgeon |
| L | Consultant Oncologist |
| M | Consultant Radiologist |
| N | Consultant Orthopaedic Surgeon |
| O | Consultant, Renal & Urology |