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Before ethics? : a study of the ethos of the medical profession

Thesis

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ABSTRACT

The thesis makes a distinctive contribution to the field of professional ethics; offering a more nuanced understanding of the role of a profession's ethos in relation to its ethics. In so doing, it also offers a valuable insight into GP thinking at what proved to be a unique moment in the history of that branch of the medical profession.

Using historical and empirical data, the thesis first traces the development of the medical profession's ethos - its belief in itself as a noble, superior profession, of special dignity and worth. It then shows the influence of that ethos in areas of professional decision-making that have had a particular impact on the provision of health care within the UK over the past 50 years. Taking the profession's ethos as a benchmark, the study explores the nature of the profession's response to the creation, control and, in recent years, major reform of the NHS which reform introduced a new emphasis on management. The latter provides a case study that relates the theoretical material to an historical situation. This includes a number of interviews with GPs that point to the beliefs and values influencing their decisions in relation to the reforms, as they affected general practice.

The study concludes that, although a profession dependant on attracting clients may find it necessary to subscribe to a set of ethical principles that draws on outside beliefs and values, it is the ethics derived from its own internal ethos that will take precedence in guiding everyday thinking and practice.

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Thesis Title: Before Ethics? A Study of the Ethos of the Medical Profession

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Glossary

A&E	Accident and Emergency Department
BMA	British Medical Association
DHA	District Health Authority
DGM	District General Manager
FHSA	Family Health Service Authority
GMC	General Medical Council
GP	General Practitioner
HA	Health Authority
HV	Health Visitor
NHS	National Health Service
NHSME	National Health Service Management Executive
NPM	New Public Management
PCT	Primary Care Team
RGM	Regional General Manager
RHA	Regional Health Authority
UGM	Unit General Manager

Introduction¹

This research arose out of the changes made to the National Health Service in the late 1980s when the government introduced a new style of management into the service. This was a major reform that met strong opposition from key groups within the NHS led by the medical profession. Ethical concerns were central to the objections raised by these groups. The reforms were portrayed as a challenge to the ethical principles of professional practice. It was this emphasis that led me to consider the role of ethics in the modern medical profession. Specifically my aim was to critically assess the relationship between the principles of standard medical ethics and the everyday thinking and practice of medicine. I argue that the ethics of everyday practice and decision-making is based not so much on textbook principles as the profession's own long established ethos.

Although I briefly outline, for contextual reasons, the theories informing medical ethics, the focus of the study is the interplay between ethos and ethics. Ethos and ethics are key terms in this study. Though these terms will be explored in depth in the following chapter, at this point I will offer a very brief standard definition of each to assist the reader in understanding the unfolding argument. Ethics is defined as:

¹ I have kept references to a minimum in this section as all the points made will be expanded and fully referenced in the body of the thesis

a system of accepted beliefs which control behaviour, especially such a system based on morals (Cambridge Dictionary, 2000).

And ethos as:

the...moral nature; the characteristic 'spirit' or 'tone' of an association, institution, society, culture or people (Merriam-Websters, 2000; Scruton, 1983, p.157).

Drawing out this subtle but significant relationship has the potential to make a valuable contribution to the field of medical ethics in particular and professional ethics in general. The strength of the study is its focus on the ethical hinterland: the ethical landscape often hidden behind the official, or formal, language of ethics professionals employ in public for discussion of such things as ethical dilemmas and hard cases.

Exploring this territory offers a clearer understanding of behaviour, attitudes, and conduct that from the perspective of the outsider will otherwise be judged as unethical. Furthermore, recognising the influence of a profession's ethos on both its explicit, or formal, and implicit, or informal, ethics offers the potential for a firmer foundation on which to construct future codes of ethics.

Thus, while the research will be of special interest to academics working in the field of medical ethics, in view of the growing interest in this subject, in both the public and private sector, the research has value to all involved in the teaching of professional ethics and devising of codes of ethics.

The study sits within the discipline of professional ethics. It is not a sociological study but rather an exercise in interdisciplinary critical reflective thinking using a variety of sources and methods to illuminate a particular phenomenon, namely the relationship between ethos and ethics. Undertaking such an exploration involves crossing the disciplinary boundaries of history, sociology, anthropology as well as moral philosophy. This is no mere haphazard eclecticism but a valid approach to a subject that in its own right crosses the somewhat artificial boundaries of traditional academic disciplines (Lupton, 1994, p.19).

In this case, taking the broader inter-disciplinary view allows insights into the nature of the medical profession's opposition to the management reforms. It also offers room for an explanation of why, when set against the ethical principles it espouses in its formal "ethics talk", the attitudes and practices of the medical profession can appear to the lay world unethical.

The Medical Profession

The medical profession operates in two distinct areas: community and hospital. Primary care is provided in the community by general practitioners with a team of other professionals including Community or District Nurses and Health Visitors. Secondary care takes place within the hospital setting under the control of various consultants each with their own team, or "firm", of junior doctors plus a full range of support professionals and ancillary staff. GPs have always acted as the main gate-keepers to the secondary sector,

patients as a rule² must be referred to a consultant by their GP. Despite this apparently key role community based medicine, or general practice, has historically been viewed within the medical hierarchy as less prestigious than acute hospital based medicine. A third area of practice is that of public health. It focuses on the health of populations as against individual patients. It, too, is provided from within the community by a small group of doctors. It is viewed by fellow professionals as the least prestigious of all the pathways open to doctors though it does offer some consultant-grade posts (Levitt *et al*, 1995, p. 171-72; Moran & Watkins, 1991).

In 1989 general practitioners were invited, even encouraged, to take responsibility for the management of much of their Practice budget. This so-called fundholding scheme was a radical move that formed a central plank in the then government's reform of the NHS. Traditionally the medical profession has distanced itself from a direct involvement in matters of finance within the NHS. Professional decisions have always been presented as based solely on "clinical need" without any reference to costs. Budget, or fund-, holding appeared to break down that barrier, making open and obvious the link between clinical decisions focused around patient need and management concerns focused around costs. Thus, the management reforms of the 1980s presented GPs with an opportunity and a challenge.

² Direct access can be gained through attendance at a hospital A&E department.

This window of opportunity and challenge was open for just one decade. It was closed by the new government following the general election of 1997. During that ten year period, however, GPs were faced with a choice: to maintain the profession's distance from management and its concerns with finance or to accept the invitation to take more direct control of the budget. My research provides a unique opportunity to hear the voice of GPs as they faced what could be viewed either as a moral dilemma or as an innovative approach to the provision of health care. How did GPs respond? What considerations informed their decision? To explore these questions I undertook interviews with GPs, both fund and non-fundholders. In order to gain a more detailed background picture I also interviewed some of the new NHS managers including a business manager, an audit manager and a practice manager.

From the interview material came the realisation that something more was involved in the decision-making process than "patients best interests" that is the emphasis of the GMC's *Duties of a Doctor* and derived from and closely allied to the now standard four principles identified with medical ethics. The principles of non-maleficence - *parum non nocere*, which is usually translated as "first do no harm"; beneficence - to do good; justice - fairness, equity; and autonomy - patient self determination (see Gillon, 1988; Beauchamp & Childress, 1994, 120ff). Values that the doctors brought to bear on their decision seemed to reflect another, albeit related, perspective, a

different view, of what was “good” or “right” in relation to professional practice.

Jonsen (1990), a professor of medical history and ethics, in a book based on a lecture he was invited to give to Harvard Medical School, provided the key to identifying and understanding this different perspective. He drew attention to a subtle, thus all too easily overlooked distinction, namely, that between medical ethics and the medical profession’s ethos.

This distinction was the key for the whole study and provided the central question for the interview data. Was the decision the GPs made informed more by the ethos of the profession or the more widely understood and publicly espoused medical ethics? Out of this came the core topic of the thesis: an exploration of the relationship between medical ethos and formal modern medical ethics.

In order not only to understand the nature of the profession’s ethos but to ground the central hypothesis in a broader perspective, I began by exploring the historical background to the development of medicine as a profession within the United Kingdom (UK). I then went on to look at the profession’s response to another seminal moment in its modern development, namely, the conception and creation of the NHS itself. These elements provided an essential context for the work. The historical research enabled me to develop a conceptual framework from within which to interpret the interview

data. I tested this theoretical material in the context of an historical case study, namely the response of the profession as a whole, and then GPs in particular, to the range of reforms introduced following what came to be known as the Griffith's report.

The Shape of the Study

The study draws on a combination of historical and empirical evidence. It is divided into two parts of equal weight. The first part, chapters one to four, looks at the construction and impact of the medical ethos through the development of the profession within the UK, and the influence of that ethos as seen in the profession's response to the creation of the NHS. It closes with an exploration of the relationship between two sets of values: those of medicine and those of management. The second part, chapters five to nine presents a case study, or paradigm example, based on the reforms to the NHS that followed the Griffiths report. This case study focuses on the position taken by the profession as a whole to the reforms and then the responses of GPs as individual doctors faced with decisions presented to them by the reforms. I chose this approach as it allows me to unpick and highlight the distinction between ethos-based thinking and practice, the informal implicit ethics, and the formal explicit ethics of the profession's public pronouncements. Thus, I am able to test the theoretical material, the hypothesis, in the context of a particular historical situation.

I show that in making its decisions on matters such as the creation of the NHS, management reform, and everyday practice, the medical profession acted according to the values and beliefs derived from its ethos even though it will often have presented its case, or defended its position, in terms of its more widely understood and acceptable ethics exemplified in recent decades in the four principles as described above.

The point of the study is not, however, to suggest that medical ethics is a mere epiphenomenon, that the profession's public pronouncements with its emphasis on ethical concerns, were or are just empty rhetoric. It is instead, to explore the argument that the stance of the profession was, and is, governed by more than a concern for publicly stated ethical principles. The aim of the research is to draw out and clarify a distinction between ethics and ethos, particularly in the context of the apparent conflict between principlist ethics theory and the reality of everyday practice and decision-making.

In making this distinction I point to two versions or types of medical ethics. The first is derived from "the ideal demanded by the public" (Loudon, 1986, p.272). It is typified in the increasingly familiar and widely discussed four principles (Gillon, 1988; Beauchamp and Childress, 1994). It has provided the basis for the published, and therefore public, guidance given to doctors by the GMC in its *Duties of a doctor* (GMC, 1995), and it figures

prominently in public debates on so-called ethical dilemmas, the “hard cases” that make the headlines. The second is a type of virtue ethics, almost unspoken and unrecognised but arising from the heart of the profession itself and informing the doctors’ view of the world of professional thinking and practice, “the daily mundane tasks of a physician” (Magee, 2000), and for which I have derived the term “the implicit ethics of practice”.

Modern principalist medical ethics has now become differentiated into several distinct branches, including physician-centred medical ethics; health care ethics for nurses and other health care providers; clinical ethics that focuses on hospital case decisions with the aid of diverse committees and consultants; and bioethics that includes general issues of reproduction, fair distribution of organs and other scarce life-saving resources, and protection of the biosphere (Ruddick, 1998), plus any variation on the above including those from a patient-centred perspective. In this thesis, however, the focus is on the two main types of ethics that I have defined and distinguished in the preceding paragraph. It is to these two types of ethics, and these alone, that I will be referring throughout the rest of the work.

Finally, at this point it is appropriate to note that the institution of medicine as a social phenomenon has been the object of close academic scrutiny over many years. This has resulted in a vast body of literature in the fields of medical ethics, sociology, history,

anthropology, and related areas. It has been impossible to explore all this material. Readers will, nevertheless, find many standard texts referred to particularly in the historical material including those offering the “outsider” view, with work from North American historians Honigsbaum (1979, 1989) and Eckstein (1958). However, it is important to emphasise that a significant number of the texts I have selected have been written by doctors. This was a deliberate choice. I wanted to give considerable space to such doctor-produced material as a means of “looking over the shoulder” of those inhabiting the world of medicine in order to better understand the aspects of that world that are the focus of this study (Schwan, 1998, p.231; Geertz, 1983, p.58).

Part One of the thesis is made up of chapters one to four. Chapter one has two sections. In the first, I outline the overall research project. I explain how the project developed from a very early and ill-defined focus on the ethics of managers; to that of doctor-managers; and finally to that of the medical profession as a whole; as seen in the approach of the profession to major changes in health care provision. In the second section I set out the methodology used.

In chapter two, I begin by looking at the concepts central to the work, namely, ethos and ethics. After offering a fuller definition of both terms I move on to look at the place of each within the medical profession. There then follows a discussion on the role of myth and

a look at the place of myth in relation to medicine's ethos and ethics, this in the context of one of the profession's central myth stories, namely, the place of the Hippocratic Oath. Another core element in the creation of the profession's ethos was its path to the status of a profession and I explore this part of the history. The chapter concludes with a section on the values informing medicine's ethos and its explicit and implicit ethics.

Chapter three develops the historical emphasis by looking back to the creation of a national health service. The distinction between ethos and ethics is identified first, in the responses of the profession to the NHS and then traced over five decades, as the profession dealt with efforts by government to address the ever-present question of how the resource-hungry Service could and should be controlled or managed. The chapter ends at the point where management reforms, the second great challenge of modern times to the profession, are introduced.

Chapter four explores the values of management and those of the medical profession. It analyses the assertion of an ethical conflict between the two sets of values by examining the medical profession's actual relationship to the concepts most closely associated with this new style of management, namely, money and profit. It then look at the profession's core value as set out in *Duties of a doctor* (GMC, 1995), namely, "patients' best interests", and set this alongside other interests that have a direct claim on professional practice. Two

further key concepts are then scrutinised, first clinical autonomy and second the value to patients of the doctor-patient relationship as it has been traditionally understood by medical practitioners.

Part Two comprises chapters five to nine. It begins with a brief summary of the main arguments up to this stage of the thesis.

Chapter five introduces a case study that will then be followed through the rest of the work. It begins with the reforms following the report of Roy Griffiths, deputy chief executive of Sainsbury's, a leading UK supermarket. Appointed by the government to find ways of making the NHS more efficient, Griffiths recommended the introduction of general management, including encouraging doctors to take on overt management responsibilities. The government accepted the recommendation and went on to introduce even more innovative reforms in the shape of the so-called "internal market" in line with the ideas of Alain Enthoven. The chapter explains and explores all these changes in greater detail. It then looks in detail at the medical profession's reaction to the changes, highlighting the contention that the reforms presented doctors with a possible ethical dilemma by requiring them to place the demands of good management alongside those of good patient care.

Chapter six contains the core interview data. This interview is the pivot for the rest of the interview data and is thus set out in full. It is preceded by a section describing the data-gathering and transcription process.

Chapter seven analyses the core interview, identifying and using thematic threads running through the data. These themes are the factors that influenced the GP's decision to become a fundholder. The values and beliefs associated with the profession's internal ethos are shown to have had a greater influence on thinking and decision-making than the principles of modern medical ethics.

Chapter eight moves the analysis to the full range of interview material using the same main themes identified in chapter seven. This chapter is divided into two sections, the first look at the interviews from the rest of the fundholders and the second sets out the views of the non-fundholders. Through this data we hear opposing views to the fundholding element of the reforms.

Chapter nine draws together the whole range of case study material, both interview and historical documentary, and discusses the findings.

The Conclusion looks back over the project summarising the main arguments and looking at its strengths and weaknesses before suggesting further areas for study arising from the research.

Part One

Chapter 1

The Research Project

This chapter has two main sections. In the first, I focus on the development of the research topic, presenting an overview and background to the issues explored in the body of the work. In the second, I set out the methodology and methods.

An Overview Medicine into Management

During the 1980s, government began a process of what Osborne (1980, p 185), has called “responsibilisation”. Following the reforms of that period a new type of management was introduced to the NHS - general management. Under general management, the emphasis was placed on principles characterising the management of businesses in the private sector. value for money, efficiency, and effectiveness. Thus, the NHS manager was no longer to be an administrator guided almost solely by the interests of doctors but a proactive manager taking control and making decisions (Hunter, 1992, p.558).

Management became the new watchword of the NHS. General managers were introduced into the hospital setting where they were required to manage "hospitals as businesses" (Osborne, 1980, p.186). In the community, GPs were encouraged to become “fundholders”, taking responsibility for, or managing, their Practice budget. The

scheme involved allocating each fundholding Practice a budget from which they would be able to purchase, within specified limits, services they considered most appropriate to the needs of their patient population.

In a study of young doctors' core values, Allen (1997a), found hostility toward management on the part of doctors. While leaders of the profession identified its core values as commitment, caring, compassion, competence, integrity, spirit of enquiry, confidentiality, responsibility, and advocacy, managers were held to have "very different aims and values". There were "great differences in culture between managers and the medical profession" that created tensions between the two groups (pp.1, 3, 8).

Thus, moves toward incorporating business management values into the practice of medicine presented doctors with a dilemma. More specifically a moral dilemma inasmuch as doctors are perceived to inhabit "a world of ethics",³ in which the interests of patients are held to be paramount. Business and management, on other hand, are viewed as having as their prime consideration rather less noble ideals focused on costs, value for money, efficiency, and profit. From that perspective a clash of values was almost inevitable as the values relevant to good business practice were seen to be at odds with those

³ This very phrase was used by the speaker in a Thought for the Day broadcast (Radio 4, February 12th. 1999). It was offered as a passing and non-controversial comment that the speaker knew to be one with which the listeners could agree and identify; as such it typifies the popular perception.

of good clinical practice (Dickenson, 1995; cf. Sheaff & West, 1997, pp.189-206).

A former chairman of the BMA highlighted what he saw as the particular moral dilemma facing one branch of the profession, namely, GPs, as they considered the fundholding option. In his view fundholding offered not only the opportunity to become directly involved in managing their budgets, but of "gaining advantage for their patients *at the expense* of those of their non-fundholding colleagues". He asserted that "in the first entrepreneurial flush of enthusiasm" the early fundholders resolved this particular dilemma by ignoring "ethical considerations" in making their decision (Lee-Potter, 1997, p.16, emphasis added). The implication was that those GPs dissenting from the profession's opposition to fundholding were acting not out of concern for overall patient well-being but for the apparently less honourable reason of putting their own patients first. In so doing they were acting unethically. However, this criticism appears to contradict the GMC's code of practice wherein the doctor is clearly told that their "primary duty is the care of *your* patients" (GMC, 1995 emphasis added).⁴ The negative presentation of the action of fundholding GPs is one to which I will return later. However, it was appropriate to introduce it at this early stage.

⁴Although this quote comes from the GMC's latest, at the time, directions to doctors it is the long standing accepted 'first duty' of the doctor.

Development of the Research Project

Originally the intention of the research had been to find out how NHS managers resolved ethical problems. However, as I became more confident in my own understanding of the issues, the focus of interest moved from the ethics of managers to the relationship between modern medical ethics and a traditional medical ethos. This section sets out that movement.

"Researcher-produced" data (Reinharz, 1992), was a central element of the work. In the early months of the project, and after discussion with my supervisors, the consensus view was that the methodology should centre on focus-group interviews based around case studies with use of a so-called "Socratic dialogue",⁵ in order to elicit the ethical reasoning process used by the individual interviewed and the moral principles that informed the decisions made. With this goal in mind, I began navigating a path to NHS managers. This proved less easy than had originally been thought, mainly because, as an "outsider", I had no direct contact with the intended interview group. Two attempts to set up such interviews came to nothing. These efforts continued at the same time as my review of the field

⁵ Defined by Stout (1988, p.301-2) as in its "bad sense asking 'Why do you believe that?' over and over again until the person you're talking to either falls silent, gets confused, or gives up and utters what looks like a fundamental principle". And as in its "good sense a kind of dialogue or reflective self-inventory in which one asks many different sorts of questions and eventually remembers what one has been committed to, without realising it, all along". The Society for the Furtherance of Critical Philosophy (SFCP, 1998), for whom the method is a central element in their deliberations and endeavours, defines it as "a kind of dialogue conducted among people who try to answer an important question on an equal footing, as peers, ...without the benefit of any special knowledge".

literature was in progress and, despite the setbacks, I was able to conduct interviews with four managers. Although these meetings were not, in the event, as central to the project as I had at first thought they might be, nevertheless, they offered insights that helped inform my thinking in this early exploratory stage of the research.

The move away from the initial research topic began as increasing familiarity with the literature raised new questions in my mind. The process was also aided by lengthy and detailed discussion with fellow researchers. Through these discussions, added to the popular image of managers presented in the media at that time, for example, in the television programme *Casualty*, it became apparent to me at least, that questions about managers and their sensitivity to ethical principles carried the assumption that in this new breed of NHS managers, moral sensibilities were rather undeveloped; that they were unskilled in moral reasoning. Unlike doctors, a group with whom they would be compared, the managers were inclined to make decisions less from concern for patients and more from concern for a good financial outcome and/or their own career prospects.

This perception was confirmed by two of the exploratory interviews I conducted early in the research programme. In the first, the pilot GP interview, the interviewee vividly portrayed the contrast between doctors and managers. This GP's view of managers was that they were only interested in money and status; they had no concern for patients or the NHS. The few who showed genuine

compassion were not going to get very far - "they are given a little office down the corridor and forgotten" - was his assessment of the climate in the reformed NHS.

The second exploratory interview was with a high-ranking former NHS manager who presented a similarly negative view of the new type of NHS manager. He had noted that prior to the reforms most managers who came into the NHS did so out of a sense of public duty. However, in his experience, that attitude of service was no longer present; the young, up-and-coming managers were merely interested in a good career path; there was little commitment or ethical awareness. His view was not uncommon as Brereton and Temple (1999), note in their study. They observed a tendency to "look back to a golden age" when the emphasis had been on personal integrity and public service, whereas today the focus was seen to be on personal gain.

Other research questions this perception. Thus, Sheaff and West's (1995), research into the ethical awareness of the "new" type of NHS managers challenged the stereotype of the ethically more permissive private sector manager. Their findings refuted the idea that recruiting new managers with a private sector background equated to a relaxation of ethical standards. Quite the opposite was the case as those with an NHS background were found to be the "less ethically conservative" (p.201).

During this early period of the research, I had the opportunity to talk with four NHS managers: three were at the time of the interviews employed in management posts while the fourth, to whom I have already referred, although still involved in the field had moved out of direct management. This opportunistic and very small sample has no statistical validity. Nevertheless, talking to them enabled me to gain some impression of the modern NHS manager which in itself was interesting and useful. I draw attention to the interviews as a record of the background information I gathered in the early days of the research.

None of the managers had a medical or nursing background. They were all in jobs created under the reforms. The youngest was a woman in her late twenties. She was the business manager for the surgical directorate in a large hospital, a post typifying the new style of management in the NHS. During the course of an hour long discussion she expressed herself in terms no less caring and compassionate than the GPs I later interviewed. There seemed to be a genuine interest in both the patients and staff of her department. The practice manager, a man in his late fifties, displayed an enthusiasm to achieve the best for "his" GPs and their patients. He was very proud that the Practice⁶ had managed to negotiate a deal

⁶ Throughout this work I follow the convention of capitalising the word practice when it refers to the business to which an individual doctor is, or group of doctors are, attached.

with one of the consultants from an internationally renowned hospital. That consultant now came once a month to the patients, most of whom lived in widely scattered rural communities. Running a clinic at the local surgery had made receiving needed health care a great deal easier for many of their patients. Another of the interviews was with an audit manager, a woman in her forties. She showed a strong commitment to the value of evidence based medicine and best practice, both for individual patients in improved outcomes and the Service as a whole in economic savings. Despite considerable obstacles she was committed to persuading GPs to look at their own treatment regimes for common conditions, compare the outcomes with other regimes and agree a protocol of best practices.

All this information, from the literature, and my primary research findings and observations, in conjunction with my growing interest in the place of ethics in medical practice, led to a reassessment of the research topic. There were now two directions in which the research could move. The first focusing on the management side, exploring the managers relationship to ethics possibly by using case studies in order to make a direct comparison of the way managers and doctors resolved a particular ethical dilemma. The second looking at the assumption that orthodox medicine is "a world of ethics". This latter approach would include exploring the distinction between management and medicine from the perspective of doctors who had become managers, specifically seeking to find what part the

principles of modern medical ethics had played in their decision to take on the management role. Were the values that informed their thinking significantly different from those identified as typifying the thinking of the modern NHS manager? By now it was the second of these two research paths that really roused my interest. Pursuing it would involve researcher-produced data from interviewing doctors-cum-managers. It was the research path down which I chose to go.

Following further discussion with supervisors, I decided that the main researcher-produced data should come from interviewing GP fundholders. I was still at that time pursuing the idea of presenting the interviewees with case studies and eliciting the ethical principles that informed their decision in each instance.

To this end I began to gather GP interview data. Thus, in the Spring of 1996, the first year of the research, alongside the very informal interviews with a range of non-medical NHS managers, I took the opportunity to attend one of the many conferences held by the British Association of Medical Managers (BAMM).

This latter was the only piece of observational research I was able to conduct. It was illuminating, inasmuch as it allowed me to hear medical managers talking among themselves about the problems and opportunities faced by doctors prepared to accept direct management responsibilities. They displayed considerable confidence in their ability to take on whatever management role was open to them, it was all well within their capabilities. "Research

shows that we are among the top 5% of the most intelligent people in the country”, was a comment made several times by one doctor-cum-manager in the course of her 30 minute presentation. I noted a determination not to let anyone else manage them, doctors must always lead whatever team had to be led. I heard the view expressed that management offered an interesting change of scene. After 20 or 30 years in the same job, a few years as a manager provided a stimulating challenge; it stopped one getting bored. There was also a concern to remind each other of the patients who were at the heart of all their endeavours. Slides showing young children looking up from their hospital beds interspersed those depicting the work of the team managed by one speaker. A chief executive spoke of the gratitude patients expressed for the care they had received in his hospital. I was also able to note that only one speaker referred directly to an “ethical concern”. He raised the possibility that colleagues could view the doctor-cum-manager with suspicion and this would affect good working relations.

All the while I was gathering this data, my own research interest was developing to the point where I was unconvinced of the value of producing another piece of research on what Pincoffs has termed “quandary ethics” (quoted by Burrell & Hauerwas, 1981, p. 79). By now I wanted to look beyond the current fashion for case study ethics with its emphasis on setting up a problem or dilemma and then identifying particular ethical principles and theories involved in the

health care and medical decision-making.⁷ I had come to think that something was missing from this approach. My interest had moved to an exploration of what was going on below the surface of “ethics talk” and understanding more of the processes that had given and continue to give ethics such a prominent place in modern medical practice. If the research was to have a purpose, it was, in my judgement, essential for wider questions about the setting in which the particular viewpoints and experiences belonged, to be given prominence in the overall project. This was a seminal point in the development of the final research question.

The Research Hypothesis

The hypothesis I set out to test in this thesis is that while a profession dependent on attracting clients will subscribe to a set of ethical principles that draws on outside beliefs and values, its working ethic, that which governs the “millions of moments of truth” (Ranson and Stewart, 1994, p. 275), of everyday practice, will always be derived from and based on its own internal ethos, one often quite distinct, but hidden, from the lay world.

The research hypothesis developed over time as I explored the literature and heard the views of the GPs who agreed to be interviewed. Each of these two main influencing factors informed

⁷ And that currently fill countless books and journals with titles such as *20 Common Problems - Ethics in Medical Care* by Jeremy Sugarmann (1999) McGraw-Hill.

and directed my thinking. I will now set down some of the texts that played a key part in this process.

An important study undertaken by Glennerster *et al* (1994), into GP fundholding included findings directly relevant to the research; covering the first three years of the fundholding project. Glennerster and his team interviewed GPs across a number of regions, they also sat in as observers on meetings including those at which Practices discussed whether or not to join the scheme.

Glennerster's team was interested to know why those who had joined the scheme in its third year of operation had not taken the opportunity to join at the outset. The reasons given during interviews were quite varied. The results showed direct reference to ethics as only one element in the thinking of GPs deliberating on an issue fundamental to their future practice and to the care of their patients. Some Practices had simply not met the original patient numbers criterion. When that was reduced, they were eligible and so had opted into the scheme. Others mentioned uncertainty as to the scheme's "political future", the hostility of GP colleagues; the costs of implementing the changes; and satisfaction with the existing arrangements.

Of particular interest were the findings discussed under the subheading 'Ethical and political concerns'. There the study noted that:

About one quarter of the sample had had major ideological doubts about fundholding...They thought it would produce a two-tier service and supporting it would be ethically unsound. There had been the fear that it would threaten the relationship with patients (1994, p.52).

Notwithstanding the confusion apparent in this quote between ideology and ethics, the subheading draws attention to the what might be seen as a somewhat surprising fact, namely, that three quarters of those sampled revealed no major ethical concerns about fundholding. Of even more interest was the team's observation that, over time all the problems, including the ethical uncertainties, "had gradually come to seem less important".

Several other studies raised very specific lines of thinking that came to play a major part in the development of the research hypothesis and an appropriate analytical framework for the research. Each clarified an element of the project and took it on to a next stage.

Jonsen (1990), led me to a reconsideration of the influence of ethos on ethics in the context of medical thinking and practice and so provided the central focus for the research. He drew attention to an important difference between the concepts as follows:

Ethics cannot be understood without ethos. All rules, principles, and virtues, while they may be stated in propositions and definitions, have a tone and color (*sic*)

different in different communities...Ethical rules and values take on a certain shading in the light of the ethos (p.62).

Yet, Jonsen observed, the two terms, ethics and ethos, are used synonymously, a conflation that obscures the significant difference between them. Papers by Sheaff and West (1997), and Brereton and Temple (1999), in which the researchers discuss “the new public service ethos” demonstrate that Jonsen’s observation is still valid. In what would, otherwise, have been an excellent paper the authors do not trouble to define ethos but are content to let ethos and ethics stand as synonymous. Brereton and Temple offer a very brief definition but only in the form of a small quote (p.2) which they themselves do not consider necessary to highlight and develop. Without a clear definition that draws out the distinction as well as the fundamental link between ethos and ethics, the articles confuse instead of clarify these inter-related but distinct concepts.

Another key text informing this research was the report of the Education Committee of the GMC (1993), on educating tomorrow’s doctors suggested that future education needed to address some of the attitudes it considered inappropriate but displayed by doctors currently in practice. These findings raised the question of a link between the attitudes to which the report alluded and the traditional medical ethos.

Fleischmann (1999), in her study of disease and discourse, explored the argument that doctors and patients do not share a

common language when talking about disease and illness. She noted "vocabulary was of little value if the conceptual world referred to is a mystery" (p.4). Thus, in her essay Fleischman looked "below the linguistic surface of the discourses of illness and disease" and attempted to "shed light on the meanings and metamessages tucked away in the recesses of their language" (p.5). This helped define the focus of my own study. My research would look beyond or beneath the apparently shared language of medical ethics, as for example in the use of the four principles and such phrases as "patients' best interests", in order to understand how the concepts hidden in the much more fundamental and, to the lay world, almost mysterious ethos of medicine shed light on the meaning of that ethical language.

Fleischmann noted that our everyday verbal transactions are assumed to be governed by what is termed in the field of linguistic pragmatics the 'Co-operative Principle'. This is the general notion that language behaviour is a co-operative interaction and that speakers craft their utterances so that the intended meanings can be properly understood, but "where this is not the case it is because other agendas have come into play" (p.28 from footnote 31). Doctors and non-doctors are assumed to share a common language when talking about medical ethics. In reality, this is often not the case. Is this because, knowingly or unknowingly, another agenda operates: one that conforms more to the ethos of the medical profession than to the principlist ethics that the patient and the

potential patient believe guide medical practice? This was the question that Fleischmann's work raised in my mind. My research, though not following linguistic models, would focus on identifying the wellspring of the profession's own understanding of the language of medical ethics.

Dopson (1996), drew attention to a particular inclination within the literature exploring the relationships between doctors and managers, namely, to do so in terms of the face-to-face relationships rather than seeing them as part of complex social structures involving differing power relationships. She therefore urged "future debates on the involvement of doctors in management...to recognise the conflict of interests that exist on a social-structural level between doctors and managers" (Dopson, p.185-6; cf. Baeza *et al*, 1996, pp.129-131). This observation resonated with my own thinking and confirmed in me a determination to look beyond an inter-personal analysis and explore the nature of conflict at the level of the dominant structures and value-systems within a profession or organisation as a whole.

The Research in the Light of Contemporary Developments

Sherwin has observed that

when intolerable abuses of [patients'] trust become public, damage control is usually initiated through renewed professional commitment to moral education and enforcing ethical standards (1992, p.86).

Just such a process has been set in train as the GMC tries to restore public confidence following revelations of unethical practices in several different health care settings that have come to light in recent months. Among them the high mortality rate of children operated upon by certain surgeons in the Bristol cardiac unit, the use in North Staffordshire of premature and young children for research into the effectiveness of a particular type of incubator⁸ without parental consent; the policy in a Liverpool hospital of removing, for research, the organs of children when parents thought they were only consenting to a standard post-mortem examination for determining the cause of death; and the routine denial of treatment to older patients. These are just some of the more highly publicised issues that have raised public concern as to the quality and ethics of professional medical practice.

A recent editorial in the BMJ set the GMC's efforts in the following context:

When the public is not in a good position to judge the quality of service, the training, qualifications, and codes of ethics and behaviour of a self-regulated profession have traditionally provided the desired protection. However, these structural characteristics of a profession are no longer enough to reassure

⁸ CNEP, a system that uses negative pressure rather than the positive pressure of standard incubators. Parents claim they were not told the system was experimental. Such experimental work requires specific consent. By apparently concealing the experimental nature of the equipment that special consent was not required.

a less deferential and better informed public....Societies now expect evidence of the effectiveness of services and of the continuing competence of individual practitioners. The introduction of clinical governance...and revalidation⁹ has been the first step in meeting this expectation for health care in the UK....British medicine has come rather late to accepting revalidation.....Recent high profile cases of professional misconduct...may have influenced the GMC's decision to embark on revalidation (BMJ 1999; pp.1145-6).

In noting that "British medicine has come rather late to accepting revalidation" the article recognises the natural conservatism that governs the profession's thinking. In many fundamental areas, for example self-regulation, clinical autonomy, informed consent, and even in the issue-centred approach to ethics and limited range of issues identified as requiring an ethical debate, or the creation and work of ethics committees, this conservatism springing from its ethos has meant that for medicine "the world of ethics" is not quite the same as that of patients and others. Doctors and the lay world have been speaking from different agendas whilst apparently using the same language.

⁹The UK government's document, *A First Class Service*, defines clinical governance as a "framework through which NHS organisations are accountable for the quality of clinical care".

Revalidation: The GMC accepted that every five years all doctors will have to submit evidence that they are practising in accordance with clearly defined guidelines.

"Revalidation will be a proactive, inclusive programme, designed to demonstrate that the performance of doctors is acceptable. It will apply to all doctors on the register, be conducted locally by peers and lay people, be monitored nationally by the GMC". *BMJ* 1999;319:1180-1183 (30)

Recognising this different perspective, understanding its origin and its influence on medical thinking and practice helps to explain what is otherwise seen, by even "sympathetic" doctor-watchers (Jonsen, 1990, p. 5), as a serious ethical problem in the practice of modern medicine. It also makes clear that if society at large, that is to say the non-medical world, requires doctors to change their practice, to give up their claims to special moral principles, to apply their ethical principles in a new way or even to adopt a different set of such principles, this can only be achieved by changing that perspective. This, in turn, calls for a change in the fundamental character or moral disposition, the ethos, of the profession.

In this context it is instructive to note that even as the profession prepared itself to accept revalidation, the BMJ article to which I have already referred began by drawing attention to the importance of self-governance to the profession. "Professional self regulation is at the heart of the organisation and philosophy of medical care in the United Kingdom". It then went on to advise that the process of revalidation "must be implemented with a light touch if it is to succeed" (BMJ, 1999). This phrase carries the suggestion that the profession is prepared to go only so far in accommodating concerns of government and lay public.

To demand a change of thinking on any of the principles the profession considers fundamental to its philosophy without having first addressed the question of the ethos out of which those principles

arise and from which they acquire their moral justification is to invite passive or active resistance. A more participatory, inclusive ethic cannot be imposed on a reluctant, unwilling profession. It must be preceded by and arise from an ethos conducive to such a set of ethical principles, one that invites a more self-critical, questioning and open approach. Appreciating the nature of the link between the profession's ethos and its ethics means that all concerned are in a better position to address the apparent ethical shortfall between expectation and reality in such a way as to ensure what Fleischmann (1999), would term a "co-operative interaction" (p. 28). In this context the research is both appropriate and timely.

Methodology and Methods

The Research Perspective

The research adopts a broadly constructivist-interpretivist perspective. Although the term can describe separate methodologies, they are also recognised as "sharing a common intellectual heritage" and "disentangling" them is somewhat artificial (Schwandt, 1998, pp.222, 245). Within that broad framework, I take a position influenced by Geertz's emphasis on human action as an hermeneutic phenomenon requiring interpretation (Geertz, 1973, 1983).

The focus is on knowledge as socially produced or constructed, arising from "complicated discursive practices". Individuals and

groups create different versions of reality and “truth” (Schwandt, 1998, p.236). Within the ‘out there’ real world humans, whether as individuals or groups, construct their own realities and their own interpretations of the common-to-all or universal reality. Thus, for example, whilst disease is a universal physical state, how it is perceived from the point of view of the individuals experiencing it or the medical profession involved in diagnosing and treating it are both constructions of that reality (Atkinson, 1995, p.23ff). These realities often overlap but equally many aspects of them are “closed” to the outsider and need interpretation.

Such interpretation involves more than knowing the meaning of the words used to describe that reality. It must include an awareness of the context, including the historical context, within which those signs and signals are set and from which they originate. Scheff, in his study on microsociology (1990, p.8), draws attention to the ambiguous and complex system of signs and signals that make up human language. Nevertheless, accurately interpreting those signs and signals is essential to creating and maintaining positive social bonds within a society, including the bonds between doctor and doctor, doctor and patient, or the medical profession and the lay community. Misunderstanding or misinterpreting those signals can damage or even break those bonds. This makes describing and interpreting the reality of an ‘Other’ more than a matter of curiosity or passing interest.

Feminist Influence

Although the research was at no stage consciously guided by specific feminist theory, I have found myself far more comfortable with many of the conventions characteristic of feminist research.

A dual emphasis on a theoretical body of knowledge and a concern with how the knowledge might be used is typical of feminist research:

much feminist research is connected to...social policy questions...Even when [it is] so-called basic research [the researcher] might conclude with suggestions about how readers can use the findings (Reinharz, 1992, p. 251).

My research stands firmly in the realm of what Reinharz calls “basic research”. Its emphasis is on producing a theoretical body of work that contributes to knowledge and as such it should not be seen as evaluative (Smith, 1975, pp 294-295) Having said that, however, I am also conscious of a hope that in contributing toward a more sophisticated understanding of the nature of the link between ethos and ethics the research will, in turn, move policy- and decision-makers away from efforts to impose from *outside ethics incompatible* with the internal validating ethos of the profession or organisation concerned.

Recognition of the value of describing not only the product of the research but also the process itself is another aspect that some,

at least, of the early feminist researchers, defined as characterising their approach (Reinharz, 1992, p.215). It is now much more widely accepted that a full discussion of the process should form as much a part of the final work as a detailed analysis of the outcome. Nevertheless, it is the example of other female and feminist researchers that I have followed in detailing my own process of research discovery.

I consciously decided to use the personal pronoun in the writing of certain sections including this chapter. In presenting an account of the research process it seemed to me wholly inappropriate to suggest that this was anything other than a personal experience. Thus, I *determined not to follow the convention* of using the third person singular a convention implying detached value-free, objectivity, the voice of truth unconnected with the feelings and experiences of the researcher involved (Reinharz, 1992, pp. 215, 231, 258).

Researcher Bias

The reflexive self is an integral part of the qualitative research process. The researcher cannot stand outside as an objective observer. Thus, the researcher needs to address and make clear her own biases in relation to the research project: the assumptions that have informed the work (see, for example, Huberman & Miles, 1994, p.439). Olesen (1994, p.165), in her overview of feminist research believes that feminist researchers should reject the notion of

bias considering it "a misplaced term", preferring instead to see the attitudes and viewpoints usually defined as "bias", more as resources. Whatever position is taken, in the interests of transparency it is important to make clear the cultural self the researcher brings to a research project.

Nevertheless, such openness is far from straightforward. The factors involved in the construction of those biases or resources are myriad and complex. Some are unknowable, for even as one attempts to reveal them, layers of what could almost be called "protective self-deception" keep them hidden from view. Others, however, are more easily recognised and can be acknowledged.

In the case of this research it is relevant to mention that over the course of several decades, I have had the opportunity to observe at close hand the medical professionals' approach to what Grayling (1999), describes as that "potentially most sensitive encounter - the doctor-patient relationship". These observations, made in the context of the treatment of those with long-term, intractable conditions and/or terminal illnesses, suggested that what might be generally understood as ethical thinking and practice is not exceptionally well-developed in the medical mind. This might be identified as one of the factors playing a part in my decision to explore the relationship between medical ethics and medical practice and to understand not only how and why the myth of the medical

practitioner as ethical hero arose, but also in what sense orthodox medical thinking and practice should be seen as ethical.

Methods

This is a qualitative research project. I am seeking to interpret a particular phenomenon, namely, the nature of the relationship between the ethos of the medical profession and the principles of modern medical ethics that are understood to guide the profession's thinking and practice.

Qualitative research presents the researcher with a number of decisions in relation to the design of the project. Having chosen the research question, the researcher must decide how to answer it. This involves not only determining what type of data is required and how it should be gathered but also how best to analyse it. What methods would be most appropriate?

Coffey and Atkinson (1996), point out that it is an over simplification to assume each type of data must have its own distinctive style of analysis which cannot cross boundaries: "There is not such one-to-one correspondence" (p.20). It is more often a case of custom-building than taking a ready made design off the shelf. The "researcher-as-*bricoleur*", selecting and piecing together, to find the most appropriate approach, or even inventing new methods and strategies (Denzin & Lincoln, 1998, p.3), is a more typical model.

Huberman and Miles (1994, p.431), suggest an important consideration in selecting the analytical framework is the relationship of the researcher to the research territory. In situations where the researcher is working in unfamiliar territory it is more useful to adopt a loose inductive approach.

Although the vast majority of the population has some contact with a GP at sometime or another, for most of us, the doctor operates in something of a closed world. That was true in my case despite the fact that all my previous post-graduate research has been medicine-based, in health economics and medical ethics. I was aware of my position as an outsider, not part of the group, someone looking in and trying to understand how and why members of that group had responded to significant changes in their society. Furthermore, this would be my first direct contact as a researcher with medical practitioners.

These factors and considerations made the research process more iterative than deductive, a case of proceeding by question and answer toward an understanding (Huberman & Miles, 1994, p.432). Thus, it follows a grounded-theory approach (Strauss & Corbin, 1994, pp.273, 276f).

The strong dialectic element of the overall methodology is apparent in the approach I took to the interviews as a whole. I saw each interview as an opportunity to actively extend my knowledge,

increase my understanding, and provide fresh insights into the place of both ethos and ethics in professional decision-making.

The Secondary Research¹⁰

I was already familiar with many of the standard works on medical ethics and knew that the quite valid approach they took was not one I wanted to follow in this research. My aim was to understand more of what I can best describe as “the general moral atmosphere” that pervaded the profession. The early months were spent in secondary research building up a clearer picture of the issues which would, in turn, allow me to sharpen the focus of the research. I have already set out the key texts that informed the rest of the analysis providing the theoretical framework for the whole research.

I then moved on to a close consideration of a range of historical data. Both that relating directly to the creation of the NHS and the development of the medical profession, focusing mainly on the UK and with a particular eye to the place of general practice within the profession. Most of this was secondary source data, written accounts by reputable historians of the period. However, I was also able to consult primary sources for events relating to the more recent past.

¹⁰ Using existing written material in contrast to primary data gathered by direct interview of respondents.

There were two reasons for undertaking historical research in this latter area. Riessman notes (p. 61), that "individuals' narratives are situated in particular interactions but also in social, cultural, and institutional discourses, which must be brought to bear to interpret them". The historical data would allow me to understand the social, cultural, and institutional discourse that was the context for the empirical material, the narrative data, that was to form the second main plank of the study. However, the historical material as a whole did more than provide a context for the empirical data. It also allowed me to trace the profession's ethos and to look for the impact of that ethos on the decisions and actions of the developing profession. Here again I was testing the validity of the theory. The question I had to answer was, did the theoretical perspective I had developed provide a coherent interpretation of key events in that history?

Using historical data is not without its problems; the most significant of which is that the data itself is an interpretation. The reader is looking at the events described through the eyes of an author or authors with all the biases (or resources) that informed the approach taken both in the selection of the material and the interpretative framework. To minimise the impact of such biases I followed the standard and obvious course of selecting a range of histories from respected researchers working in the mainstream of the field. I have also noted in this text any major interpretative

differences that had a direct relationship to my own account (Tuchman, 1994, p.318ff).

Interview Method

I leave the description of the interview sample to chapter six as a prelude to the interview data itself, at this point I want to concentrate on the interview methodology alone.

Through the pilot interview, I was able to get a clearer picture of how the GP interviews should be conducted. Which approach would enable me to collect the material in which I was now interested? My aim was not to gather precise quantifiable pieces of data, but to encourage the GPs to tell their own accounts of the fundholding decision; to hear and understand the factors and issues that had influenced each GP's attitude and approach to that option. Thus, I decided not to pursue the case study approach but to use an open interview method to gather my primary data. Using the pilot interview as a guide, I devised a loose interview schedule, a topic list around which a discussion could take place (see Appendices B & C). In terms of each interview, this flexibility let the interviewee develop a line of argument that seemed of particular importance to him or her and allowed me to clarify and check my understanding of points as they were made. Across the range of interviews, this open approach offered the freedom to follow new lines of questioning as my understanding of the issues developed over time. Had I selected a highly structured interview method such as the questionnaire, there

would have been no room for any such adjustments (Fontana & Frey, 1994, pp.363-366).

Another factor influencing my decision was consideration of the interview group itself. GPs are well used to taking the lead in the interview setting and if they felt too constrained by the style of interview they may well have brought our meeting to a speedy conclusion. Hence, I judged it inappropriate to use Socratic dialogue based around vignettes and case studies. That approach would not only have narrowed the focus of the interview but may well have antagonised the interviewees with what might be perceived as an interrogative manner. Besides which, despite the favourable light in which case studies are now viewed, they are not without their serious drawbacks, as even keen proponents of this method recognise. These drawbacks are significant enough, in my opinion, to call into question the validity of the conclusions arising from using the method as a basis for interview (Coope, 1996; Pattison *et al*, 1999).

However, the chosen approach still did not permit the degree of flexibility I subsequently came to appreciate would have been desirable. Only one of the interviews allowed me to hear the views of both the partners involved in their Practice's fundholding decision. In the remainder of the interviews, I was able to speak to only one partner in Practices that comprised at least two partners. I was always asking the interviewee to look back on events that had occurred several years earlier. Every interview was, thus, a single

snap-shot of the events as recalled and reinterpreted with the benefit of hindsight by in most cases just one GP partner. Furthermore, there was no opportunity for further interviews. Even though the open style of interview allowed me to check my understanding of a particular point with the interviewee it was still a one-off, time limited interview.

Had the interviews been intended to stand alone, such snap shots from a relatively small sample of respondents would have seriously undermined the validity of any substantial findings I attempted to draw from them. However, the research project was designed to obviate any such limitation. The interviews were constantly being informed by the wider historical analysis. Furthermore, it was my specific intention to build on each of the interviews so that questions raised but left unanswered in one interview could be revisited, albeit with a new interviewee. Each interview was informed by the previous ones and thus, I gathered what proved to be a rich source of empirical data.

Nonetheless, it would have been illuminating to have been able to gather data over time, possibly even from a Practice's initial discussion on fundholding, right on into full involvement some years later. Thus, with my own benefit of hindsight I would have preferred a non-participant, observational approach; selecting two fundholding practices to observe and interview on several occasions; sitting in on the early discussions and debates as well as later fund meetings.

Having the opportunity to speak to all the partners and hearing their concerns or expectations first hand, would have undoubtedly provided a much more satisfying picture, one of considerable depth and breadth. But, it is highly unlikely that any GP practice would have granted me such access and, whilst the experience would have been intellectually stimulating, Glennerster's (1994), findings, where his team was able to gain such access, led me to conclude that such an approach would not have added fundamentally to these research findings.

Hearing the Story

Herrnstein Smith defines narrative as "most minimally and most generally....someone telling someone else that something happened" (quoted by Mishler, 1986, p. 148). All the doctors were invited to talk about how and why they made the decision they did regarding fundholding. Each of them recounted the events surrounding and subsequent to the decision from their perspective. The decision-process was at many points illustrated with particular stories. Thus, the interviews allowed me to construct a narrative of each Practice's decision regarding fundholding.

Quoting Hardy's assertion that "we remember in narrative", McIntyre observes "we always move towards placing a particular episode in the context of a set of narrative histories....It is because we all live out narrative in our lives and because we understand our

lives in terms of the narrative that we live out that the form of narrative is appropriate for understanding the actions of others” (McIntyre 1985, pp. 211-212). In arguing for the central role of narrative Burrell and Hauerwas suggest: “Our grammar displays the moral direction of our lives” (Burrell & Hauerwas, p.84). Medicine as a profession has been described as story-based (Goldberg, 1993, p.1). In telling the story of why they did or did not become fundholders, I believe the doctors concerned not only revealed something of their own moral character or spirit but also that of their profession.

According to Riessman (1993, p.3), “traditional approaches to qualitative analysis often fracture these text”. One researcher describes the process thus:

As the process of winnowing the data begins, the emphasis becomes one of selecting one poignant exemplar after another as all of the significant “wheat” (i.e., that data which is deemed significant or exemplary) gets separated from all of the non-significant “chaff” (i.e., that data which is determined to be non-significant or redundant).

In order to minimise this problem he advises fellow researchers:

to take great care to situate their data so readers can have an appreciation of “from whence the data came” and can begin to evaluate the meaning of the data in context (Hopper, 1986, p.199).

With this in mind, I was concerned to respect the integrity of the interview and interviewee, not to so deconstruct and reconstruct the data that the original material would be unrecognisable. Thus, after gathering all the interview data, I decided to set down one GP's story of the fundholding experience in its entirety. This is a guided narrative that has a considerable degree of analysis embedded within it. For that reason the transcript belongs in the body of the text rather than in an appendix.

I considered an holistic analysis, involving looking at the whole account for interpretative themes and patterns, the most appropriate for this type of data (Riessman, 1993, p.3; Lieblich *et al*, 1998, p.15). Presenting the core interview in such detail makes transparent the context from which the themes emerged in the original interview and thus gives the reader an opportunity to judge the validity of the analysis. Furthermore, it allows an opportunity to "hear" the interviewee's story in its entirety. The data can be set above the background noise of "biases, prejudices, interests, values and viewpoints" that even the most scrupulous narrator cannot but help bring to their account of a narrative (Pattison, *et al*, 1999 p.44; Fontana & Frey, 1994, p.372; cf. Collins, 1998). It also shows the informal and at many points almost conversational style of the interview.

Apart from this one complete text, material from the other interviews appears in the same way as, for instance, Strong and

Robinson (1990), present their ethnographic studies of NHS management, and Allen (1997a), her research on core values of young doctors. Direct quotes are only used to illustrate an argument or central point. Setting this data alongside the core interview themes allowed me to test further the validity of the analysis. I could hear how the themes related to the views and experiences of both fundholding and non-fundholding GPs. Was the position of non-fundholders shown to be significantly different? If yes, that in itself would suggest a flaw in the research hypothesis. Equally, if the views of other fundholders showed a very different approach to the issues raised that again would question the research position. Thus, it was particularly important to note and discuss areas of divergence in order to determine the significance of their impact on the overall analysis.

The whole process is quite subjective. Such a mass of data provides an almost endless set of possible lines of enquiry. It is up to the researcher to decide which particular line to pursue. Once that decision is made the researcher has then to decide how the data is to be presented and interpreted. All data is open to a range of possible interpretations but qualitative data even more so (Lieblich *et al*, 1998, p.63), and especially, as in this case, when the research is aimed at identifying that which may not necessarily be well-understood by the decision-makers themselves. Such a degree of

freedom presents interpretative dangers. For that reason it has to be rooted in a more substantial data base.

Beyond the range of views expressed in my interview data, I was also able to refer to that obtained by other researchers in the field, such as Glennerster *et al* (1994), Strong and Robinson (1990), Allen (1997a), Matthews and Bain (1998), and a range of other sources including a very moving autobiographical account by one GP who lived and worked in the East End of London (Widgery, 1992). This additional data set the views of my sample of GPs in the context of the wider medical world and enabled me to answer the question of whether the views and experiences I had heard expressed were 'one-offs' or of a piece with those of the generality of doctors.

Data Analysis

The interviews were, in the main, narratives. Most of the GPs told the story of their experiences of facing and dealing with the option to become fundholders. These were generally descriptive accounts but included their own feelings and attitudes toward fundholding both in relation to the issues it raised and the actions and reactions of colleagues to their decision.

In order not to distract from the holistic emphasis of the study, I decided not to undertake a "detailed description of linguistic features of spoken discourse". Nevertheless, narrative material requires narrative analysis (Mishler, 1986, pp.3, 6, 7, 96). But this takes many analytical forms from formalistic-structuralism to the loosely

formulated 'almost intuitive' (Manning & Cullum-Swan, 1994, p.464f; Riessman 1993). The information I was seeking was embedded in the stories. The aim of the analysis was to identify and draw it out; to find from their accounts the factors that influenced each GPs decision.

After each interview, I read through the interview record, usually a transcript but on occasions a written record, noting in the margin all the words, phrases, and longer accounts that suggested an influential factor. Once all the data was gathered, I went back over all the annotated texts looking for common influences that became the themes, or analytical categories. Such themes are ideas that figure "importantly and repeatedly" in analysis, unifying the texts (Riessman, 1993 p. 67; Lieblich *et al*, 1998, pp.62-63; cf. Hycner, 1985). I was also looking out for non-standard responses as well as comparing the views of non-fundholders with those of fundholders. It was essential to consider their impact on the overall analysis.

Although computer programs exist to help with qualitative analysis I chose not to use any of them. The amount of data, whilst considerable, was not so great as to be unmanageable for one person. I did not want to lose touch with the context of the data with which I was working (Denscombe, 1998, p. 219).

The themes were then set within the wider theoretical framework testing its validity as an interpretative tool. What did those themes reveal? Could the perspective shown in them be

coherently explained by the theory? Finally, did the interpretation validate the research hypothesis?

A Transdisciplinary Multi-method Approach

For long years the traditional research position was that of staying within one's own discipline, recognising "the disciplinary proprieties" (Campbell, 1987, p.230, footnote 28). This narrow approach has increasingly been rejected, in no small measure due to the influence of feminist research, and now much mainstream research operates in a climate of blurred disciplinary genres, adopting a transdisciplinary approach (Kincheloe & McLaren, 1994, p. 140; Reinharz, 1992, p.250).

McGee (2000), argues strongly that even though using the transdisciplinary approach may not be as "marketable" as the traditional system of the single discipline, it is, nonetheless, essential when exploring medical ethics. In undertaking this research, I too, recognised the need for a transdisciplinary approach; crossing disciplinary boundaries in order to understand the complex of factors that have constructed modern medicine's relationship to ethics. I wanted to look beyond the particular moral principles that guided an individual's response to a so-called ethical dilemma in order to understand the historical and socio-cultural context out of which the individual's approach developed and in which it is set. This has resulted in a far richer study.

Thus, as well as hearing views of individual doctors, both fundholders and non-fundholders, via direct interviews and searching relevant medical, and medically related, literature in order to find the medical profession's response, or rather responses, to fundholding, *the transdisciplinary approach has freed me to explore the three main historical strands relevant to the study, namely, the development of medical ethos, the relationship of the medical profession and specifically that of the GP up to the 1980s reforms of the NHS; an exploration of parallels between values informing medical practice and those of business management.*

Taking this route established the research on a firm foundation of empirical and historical data. From that position, I was able to move on and look afresh at the *ethics of the medical profession* focusing on the relationship of the professional ethos to ethics.

The multi-disciplinary approach called for more than one research method. As indicated by Coffey and Atkinson (1996, p.4), this is now a standard, widely accepted approach to gathering and analysing data, generating and testing theory. Once again, this is an approach to research if not pioneered then certainly nurtured and developed by feminist researchers. It remains characteristic of the feminist approach (Reinharz, 1992, p.243). As Reinharz notes: "the multi-method approach increases the likelihood that...researchers will understand what they are studying, and that they will be able to

persuade others of the veracity of their findings (Reinharz, 1992, p.201).

Strengths and Weaknesses

The Interdisciplinary Approach

Using an interdisciplinary approach sets the research question in a broader framework, making visible more of the context in which the particular study fits, with the result that the multi-faceted nature of the research question is highlighted and understood. It provides the opportunity to approach the study from different perspectives, thereby enabling a more nuanced analysis than can be achieved by addressing the question from just one perspective (Lupton, 1994, p.19). This holism is the essence of qualitative research. It is also increasingly recognised as an essential approach to the study of medical ethics (McGee, 2000; cf. Morison, 1981).

In the present study this approach has allowed the particular, in this case, the response of GPs to fundholding and the ethical conflict this was perceived to create, to enrich our understanding of the broader question, namely, that concerning the relationship between ethos and ethics in modern medicine. Drawing links between a contemporary situation and its wider context both past and present, and between the actions of the individual and the socio-cultural framework within which the individual operates, results in a clearer picture of the complex way in which ethics functions within modern medical practice (Reinharz, 1992, p.197).

Lupton (1994, p.2), notes that while an interdisciplinary approach is “stimulating in its breadth” it can be difficult to know where to draw the boundaries. Similarly, Coffey and Atkinson (1996, p.14), endorse the value of a sensitive use of a combination of methods in order to draw out the complexities of a particular social situation and to produce a rich and variegated analysis. Nevertheless, they warn against "a randomly eclectic approach" and the simplistic view that a "more authentic" picture emerges from using a variety of approaches.

These cautions serve as a reminder of the need to select the range of methods with great care; a mish-mash of methods obscures the analysis and turns complexity into confusion.

The Open Interview

In the open interview, that is to say the interview that has a more loosely structured framework than is the case with, for example, a survey questionnaire, the researcher may have no more than a few main themes in the form of a checklist around which to frame questions and where specific lines of questioning will often be directed by the unfolding interaction.

Some of the strengths and weaknesses of this situation are fairly obvious. The interviewer has room for greater flexibility and can allow the interview to move off in an unforeseen but relevant and worthwhile direction; the interviewee can feel more relaxed, less

dominated by the presence of a tight interview schedule that is obviously controlling the interview, and therefore free to develop and expand on themes that they consider important or points they want to make. After discussing with supervisors and colleagues the particular demands of interviewing doctors - professionals skilled in dealing with, and controlling, the interview situation - I considered that it was important to create a non-threatening atmosphere that encouraged as free an exchange as possible, one that left the doctors feeling, as far as was practicable, in control of the situation, particularly the length of time of the interview. An open interview seemed the best way to achieve these results.

I have already noted what could have been a weakness of the interviews conducted for this research, namely, that they involved only one interview with each interviewee. The single open interview offers the interviewee-as-narrators' interpretation of the events discussed and yet the decision regarding fundholding was taken by the whole Practice which must have included at least one other partner. Each interview is one individual's interpretation of a decision-making process that involved the views, opinions, concerns, of possibly a number of other people. This range of views, concerns, and opinions, some of which may well have been significantly different to those expressed by the interviewee/narrator, were then interpreted to the interviewer through that single interviewee's frame of reference.

It is important to stress that the interviews were not conducted with the aim of getting a factually accurate historical account. Rather, in the context of the research as a whole, the narratives were valuable for the insights they offered on the thinking of the individuals concerned, the GPs' own perceptions of the often very difficult decision presented by the fundholding option.

The Research Ethics

The ethical issues most pertinent to this research project relate to the empirical material. It is on these that I focus. Furthermore, most of the section centres on the interviews with GPs. The other interview material, though useful, was gathered to provide background information rather than viable empirical evidence.

Confidentiality and Anonymity

All those interviewed, including the managers, were guaranteed confidentiality and anonymity. Thus, throughout the entire thesis I have made every effort to remove any information that might identify the respondents.

Power Relations: empowering the respondents

One of the issues that has raised considerable concern among researchers undertaking interviews is that of empowering the respondents. Collins (1998), quoting Oakely, describes the "model interview" as one where "a more or less aggressive interrogator 'grills' their unfortunate captive" (1.6). Mishler notes that "in the

mainstream tradition the interviewee-interviewer relationship is marked by a striking asymmetry of power" (Mishler, 1986, p.117). A major reason for this concern is that such an imbalance of power in favour of the interviewer prevents the interviewee expressing themselves in their own "voice". Instead they are pushed in the direction of responding in ways that they perceive as acceptable to the interviewer. One element that is seen as imposing the interviewer's authority over the interviewee is the interview schedule itself. The use of the schedule appears to give no room for the interviewee to move off in directions that are important to him,¹¹ and even if they have the courage to do so, the thinking is that the interviewer sees this as an unnecessary digression and will be anxious to bring the interview back to the interview schedule, back under her control (Mishler, 1986, p. 122; Reinharz, 1992, p.232).

None of these concerns played a significant part in the interview data that I gathered. As Atkinson (1995), points out oral skills are an essential part of the medical world. "Medical work is constantly produced and reproduced through narrative and other language skills. The competent practitioner is adept at describing his or her work and of persuading others to share opinions on the cases in question" (pp.90-91). Not only are doctors skilled in expressing themselves but also in controlling the interview situation (Atkinson,

¹¹ I will use the pronoun 'him' when referring to interviewees as the majority of my interviews were with men.

1995, p.134, quoting Mishler & Clark, 1992). In discussing with more experienced researchers my intention to interview GPs the general opinion was that they were a particularly difficult interview group. Rather than an anxiety in terms of an imbalance of power favouring the interviewer, the concern was, if anything, in the other direction. The GPs were much more likely to intimidate the interviewer than vice versa.

Nevertheless, I was concerned to ensure that the interview experience was unthreatening to both parties; I wanted to “engage” (Collins, 2000, 1.6), with the interviewees and had no desire to antagonise them or create an atmosphere of hostility. Thus, I determined to ensure that the GPs had as much freedom as possible to express themselves as they saw fit. By so doing I considered it much more likely that I would gather material of value to the overall research project. This was a significant reason for adopting the topic interview schedule I have already described, a schedule I used only as a very general guide, rather than a text to which I had to adhere slavishly. All the interviewees were aware of the schedule and its role in the interview.

Another element of the power imbalance argument is that, as Mishler puts it, “researchers through their analyses and reports define the ‘meaning’ of responses and findings, whereas respondents have no opportunity to deploy interpretations of their words and

intentions. This way of doing research takes away from respondents their right to “name their world” (Mishler, 1986, p. 122).

Again, this concern was not one that I considered relevant to the research data gathered for this project. None of the GPs interviewed showed any anxiety with regard to the interview process, all were confident and competent in expressing their views. Only one showed any interest in seeing the final research product; none asked to see the transcription of the interview data let alone to be involved in the process of analysis and interpretation. I have no reason to believe that there was any concern on the part of the GPs with “their right to ‘name’ their world”. That is not to say they were ignorant of the overall research project; each of them knew that their interview was one of several I was undertaking and that the interview material as a whole was part of the research data for a doctoral thesis; a project that would involve analysis and interpretation of the data they had, by agreeing to the interview, shown a willingness to supply.

Summary

The two strands of evidence presented in the study must be viewed as equally significant. They reinforce and balance each other. The interview data is given weight by being set in a verifiable historical context and the historico-cultural data is validated in the experiences of the GPs as the inheritors of that history and culture.

The research design I chose provided a solid framework of historical data from which to explore the research question. The

empirical data allowed me to hear the concerns and interests of GPs as they faced the challenge of the changes wrought by the reforms. Rather than any overt espousal of modern principlalist medical ethics, the GPs concerns were expressed in terms of another set of values that seemed, for them, to carry moral weight. Linking their views to the insights gained from the historical material led me to develop a theory that offered a coherent and persuasive interpretation of the relationship between the medical profession and medical ethics.

One last point that must be made is that the research process that I have described was more overlapping and circular than it appears when set down on paper. It was not a case of putting each element in place before moving on to the next stage. Many times I went back on myself, looking again at something that I had thought complete, only to find that its contribution had fundamentally changed. The process as a whole was dynamic and ongoing coming to final shape only at the very end.

Chapter 2

Ethos and Ethics

Ethics has now taken centre stage in medicine, if not always within the profession itself at least in much of the debate about the practice of medicine conducted by interested onlookers. However, as noted by Jonsen (1990, p.62), "ethics cannot be understood without ethos". Yet much of the recent emphasis has been on medical ethics with discussion of the medical ethos remaining inchoate; less well-developed. Obviously the two terms are closely related but they are not synonymous. This study focuses on the nuances of the words, drawing out distinctions and relationships that have often been overlooked.

The Medical Ethos

The medical profession values itself highly, and is so valued by others. Medicine is seen to be of "the greatest benefit to mankind" (Porter, 1997). The practice of medicine is widely perceived to be a moral activity, "those who operate on the margins of human life and eternal destiny are regarded with a certain numinous awe, and...expected to uphold a high ideal of personal and professional commitment" (Whipp, 1997); "medical practice is moral practice" (Savalescu, 1995). Medical ethics, and particularly the widely approved "principalist ethic" (Aoudjit, 2000; cf. Gillon, 1988, 1995; Beauchamp and Childress, 1994), are seen as guiding the profession and its practitioners. Thus, according to the GMC's code of conduct:

Patients must be able to trust doctors with their lives and well-being. To justify that trust,...as a doctor you must: make the care of your patient your first concern... [An] essential element of this...[is the] observance of professional ethical obligations (GMC,1995, inside cover and p.2).

It is the assertion of this thesis that within the profession itself, however, it is the ethos, the fundamental moral character, disposition, or spirit, that actually informs and underpins everyday practice, including the profession's response to or interpretation of the four principles. This traditional ethos provides the profession with its own sense of what constitutes the right or the good; what it believes about itself. It is the moral atmosphere or climate out of which the profession's ethics arises and in which it is sustained.

Whereas ethics is usually quite explicit, with a clear and precise language, ethos is much more implicit, closer to the "ancient tangle of practices, beliefs, judgements, and emotions" of Geertz's description of common sense as quoted by Scheff (1990, p.138). This is not to suggest that ethos is the same as common sense, but it is interesting to note what Scheff points to as the "taken for granted" and "goes without saying" character of common sense (p.139). In the sense of its unspoken, perhaps even indefinable authority, ethos can helpfully be viewed as the moral "common sense" of a profession. Its influence is seen, not only in the way the profession interprets and applies the ethical principles it espouses, but also in the

response it makes to ethical values that those outside the profession may wish to impose .

In the next section I will set out to identify the established medical ethos. However, if we are to fully understand the impact of its traditional ethos on the profession, that “ancient tangle” of ideas, beliefs, and values must be unpicked and closely examined. This is most effectively achieved by looking at the place they hold in the attitudes and practices the profession’s young practitioners are encouraged to absorb; in the key historical developments of the profession; in the important myth stories the profession tells about itself, and in listening to its deliberations on matters of professional concern. These are the elements that will take up much of the remainder of this study.

Identifying the Medical Ethos

Loudon (1986), identifies the mid 18th to mid 19th centuries as the period during which the main shape of the medical profession was established. During this time the profession:

was profoundly affected by two [conflicting] considerations.

First, there was the need to attract patients in order to survive; secondly, there was the need to follow the traditional codes of behaviour in order to perpetuate the higher status of the physician [over his “lesser” colleagues] (p.273).

All the other aspects of the profession, including medical education, were “superimposed” on a foundational structure, that

“had little to do with...the medical care of the population, but that had a great deal to do with the ideals of class and social position, and the growth of gentility” (*ibid.* p.273-4).

Jonsen (1990), identifies within the profession what he calls “the ethos of nobility”. He writes of the “noblemen of modern medicine”, persons of account who, in their own words, made medicine “a profession of cultivated gentlemen”, endowed with a strong sense of their own worth and dignity for whom the ethics of “*noblesse oblige*” applied (pp. 64, 65). “Doctors”, in the words of one distinguished practitioner, “were largely held to be gentlemen to whom deference was due” (Shock, 1994). Under the guidance of such men, the profession found its distinctive moral tone or ethos: the conviction that it was a noble and exalted profession; superior, exclusive, scientific, and detached. This “ethos of nobility” arose from a finely developed sense of professional worth and dignity, and encouraged the development of values that, to the outsider at least, often translates in to arrogance and an excessive, even ruthless, defence of the privileges the profession has worked so hard to acquire (Jonsen, 1990, p.68).

Social status, self-protection, advancing the interests of the profession as a whole, and safeguarding it from outsiders, all came to be highly regarded along with values of loyalty and secrecy. Finally, an inordinate respect was paid not only to the right of the individual practitioner to unquestioned freedom of practice, or clinical

autonomy, but the right of the profession to regulate itself - the defining characteristic and core tenet of the true profession (Freidson, 1970, p.137ff). Thus developed the model professional: the expert medical adviser self-regulating, uncritical, aloof, clinically autonomous, and infallible, deferred to by lesser colleagues and requiring unquestioning obedience from patients "for their own good" (Sharpe & Faden, 1998, p.232, cf. Davies, 1996a, p.6).

Guided by this ethos, medicine sought and achieved a status and respect that it had hitherto lacked and which, despite the very different world scene in which it must now operate, it in large measure still enjoys. Thus, when the editor of the *Lancet*, a respected medical journal, presented a study of the modern role of the profession's Royal Colleges, including interviews with all the College Presidents, he pointed out that these leaders receive knighthoods as a matter of course and lunch on a regular basis with high-ranking government ministers and officials. The Royal Colleges, whilst "often run along the lines of prestigious gentlemen's clubs", are powerful and wealthy institutions governing not only the medical profession but also many important areas of the NHS. In the main they operate behind closed doors with their activities remaining beyond scrutiny by those outside the profession, "secrecy is the glue that binds the profession together" (Horton, 1998b).

Other authors have pointed to further elements that have helped create and maintain the ethos of the medical profession:

As a high status profession it has a disproportionate intake from the public schools and as a result has been subject to the *traditional authority values and relationships* that tend to typify such establishments. Once entrenched in a well-established profession, such values and practices are difficult to displace since entry, training and promotion are largely controlled by the profession itself (Hadley & Forster 1983, p.162, emphasis added).

Davies identifies all these attitudes and values as “celebrating and sustaining a masculinist vision” (Davies, 1996, pp.669-671). The traditional medical ethos - the belief in itself as a superior and noble profession - provides the moral tone for all its thinking and actions. It is the product of a society dominated by a middle-class, male world view concerned with status order, control, and “proving one’s self”.

Medical School and the Medical Ethos

The training undertaken to qualify for entry into the profession not only teaches the knowledge and technical skills required to practice competently but also the profession’s norms and values. This “hidden curriculum grounds a professional life world” (Edgar, 1995, p.151). Thus, it is in the medical school that students will be introduced to the traditional medical ethos as they become immersed in medicine's own sub-culture. For centuries now the "impressionable young man..., in the boisterous, jovial sporting

atmosphere of the all-male medical school with its student high-jinks and horse play, [has been] initiated into the brotherhood, acquiring the *esprit de corps* that helped doctors to present some kind of united front” (Porter, 1997, p.356). In this atmosphere, the often idealistic medical student begins the journey to becoming the stereotypical noble practitioner of a noble profession.

Porter goes on to quote Dickens description of the medical students of his day as "young gentleman who smoke in the streets by day, shelter and scream in the same by night, call waiters by their Christian names, and do various other acts and deeds of a facetious description". They carelessly joked at the dinner table about their dissecting activities, enjoying the discomfiture of their non-medical fellow diners as they referred to their servings of meat as if they were parts of the body of a child (*Pickwick Papers*, quoted by Porter, 1997, p. 357; cf. Loudon, 1988, p.271ff).

In recollecting his own medical school days during the early 1980s, one doctor's account reveals that the atmosphere of the medical world had changed very little from Dickens' time. For its powerful description of the way the modern medical student acquires the medical ethos, it is a passage worth quoting at some length:

When I started at Cambridge University in 1981 the first patient I saw was a dead one. *Without any attempt at moral guidance*, we were encouraged to cut up our body into increasingly smaller pieces, roughly in line with the textbook.

Some students fainted, a few juggled with kidneys or skipped with intestines. I practised spin passing with a heart. One amusing man stuck a hose in one end of the gut and blasted the contents out of the other. How we all laughed....Human dissection was a rite of passage, the one thing that separated us from other students....In 1984, when I started clinical medicine in London, the similarities between medical school and public school were obvious. The Dean was head boy, the consultants were prefects and everyone else was a fag. The fags were finally free from the constraints of pink chits and lights out at 10.30 p.m. and they went wild - but in a very conservative way....In private, anything went....Our japes were small by comparison to those of our predecessors, allegedly. (Hammond & Mosley, 1999 pp.8,9 emphasis added; cf. Sinclair, 1997, p.96ff¹²).

There was no need of explicit moral guidance for the atmosphere of the dissecting room set an implicit moral tone. In medical school as well as learning technical skills the student absorbed the ethos of the profession they were training to enter:

The most important rule of all was “what goes on tour, stays on tour”. You could do what you liked but you mustn't drop your mates in it when you got back....Like the Masons....we were bound by codes of loyalty and secrecy. Break them at

¹² This book came to my attention just as the thesis was about to be submitted. A more recent account of medical training, it arose from an anthropological research project undertaken by the author, himself a medical doctor.

your peril. For those who played rugby, there was the unspoken promise that we would be looked after when it came to house-job applications. We were just the sort of bloody good chaps that make jolly good doctors. Although I committed myself to rugby at my interview (it was virtually the only question I was asked), I soon lost faith in treading on people in the name of sport and gave up. With this died my one chance of a teaching hospital job, (Hammond & Mosley, 1999, p.4; cf. Sinclair, 1997, p.112ff).

In 1993, the Education Committee of the GMC (GMC, 1993), issued a report recommending changes in the method of training new doctors. These recommendations showed up further aspects of the *ethos of medicine*. The Committee expressed concern at the overload of factual material that formed the main component of the medical curriculum (10).¹³ This, it noted, taxed the memory but not the intellect. It worked against independent thought and a questioning and self-critical practice. Although long recognised as “calculated to obstruct the acquisition of sound knowledge and to too heavily favour the crammer and the grinder” little progress had been made in altering this traditional method of bringing on the next generation of medics. The GMC Committee found that despite “repeated exhortations” (11) and the recommendations of other

¹³ The Report is presented in numbered paragraphs and that is how I will reference it.

committees (for example, the Todd Report or Royal Commission on Medical Education in 1965-68) the emphasis in the curriculum remained largely unaltered.¹⁴ Although the profession likes to consider “spirit of self-enquiry” one of its core values, the established medical curriculum has actively discouraged such a spirit; a finding confirmed by the BMA’s own research (Allen, 1997a, p.2).

The research-based agenda of most doctors involved in medical teaching has been identified as a significant factor in the profession’s insistence on facts and technical skills. This emphasis can create a conflict with the more “innate” humanistic skills such as compassion, caring, and empathy (Good & Good, 1993, p. 91-94). Yet, it is a lack of these humanitarian skills rather than of technical prowess that lies at the heart of many of the stories of “complaint and failure filling modern medical journals” (Matthew & Bain, 1998, p.7).

In its recommendations, the Committee Report (GMC, 1993), focused on a number of aspects that it had identified as detrimental to doctor education. “There is a persisting drive towards an unrealistic degree of completeness in the curriculum” (17). Here is reinforced the medical profession’s ideal of doctor as unquestioned expert. The doctor knows best, his advice is to be respected and followed.¹⁵ This is recognised as unrealistic in light of the increasing

¹⁴ Or rather, curricula for each medical school has vigorously maintained autonomy in devising its own curriculum.

¹⁵ Witness the well-understood and oft-used phrase to describe medical advice, namely, “Doctor’s order”. The clear implication is that this advice is not to be ignored.

complexity of medical science, yet the profession appears unable to let go of the illusion of the all-knowing doctor.

Closely allied to this finding the Committee also called for doctors to be taught “appropriate attitudes” (38) including, respect for patients and colleagues, a willingness to submit to audit,¹⁶ peer-review of their practice, and the ability to cope with uncertainty (40.3). These, it considered as important as the more traditional knowledge and skills associated with the practice of medicine and set out in the Medical Act 1983. In the view of the Committee the time had come to include these positive attitudes in the curriculum.

In making its recommendation, the Committee showed a recognition of a traditional emphasis that encouraged doctors to hide uncertainty, guard their clinical autonomy, and pay no more than perfunctory attention to the views of patients and “lesser” colleagues. These characteristic attitudes, core elements of the medical ethos, have long been passed onto the next generation of practitioners often indirectly, even unconsciously, in the example set by teachers and other superiors, as well as more openly in the curricula of the various medical schools.

¹⁶ The audit manager I interviewed spoke of the great difficulty of persuading GPs to agree to be audited. The process called for a considerable amount of tact and reassurance. GPs were highly sensitive about submitting their practice to outside scrutiny. Many simply refused to agree to the process. For an informative study of the attitude of doctors in general toward audit and peer review see Black & Thompson, 1994.

Whilst doctors will admit to these failings they are inclined to dismiss them as of the past; “In the past doctors abused patients trust by being less than honest or grunted at patients and sent them off with a bottle of pills” (Matthews & Bain, 1998, p.36). However, this approach is somewhat disingenuous and in itself shows that the attitudes criticised are still not being fully addressed by the profession at the level of everyday practice. Many patients continue to find this dishonesty and lack of respect as prevalent today. In his report, the chairman of the Bristol Royal Infirmary Inquiry, Professor Ian Kennedy, described the doctors involved as displaying “a type of professional arrogance: an arrogance born of indifference” in their dealings with the parents of sick and dying children. He observed that the doctors concerned “acted with good intentions *as they saw it*” (Bristol Royal Infirmary Inquiry, emphasis added). The phrase “as they saw it” summarises the role and influence of the medical ethos. The doctors concerned acted according to what they saw as good and right. Theirs was the implicit ethics of practice guided by and arising out of their ethos, and through which they learnt how to see and judge situations.

The very same attitude is revealed in the actions and justifications for those actions offered by doctors involved in the removal of organs from bodies of deceased children without parental consent. Whereas parents saw the secrecy and false assurances offered by the practitioners as arrogant and unethical the doctors

themselves had a very different perspective. Thus, Professor James Lowe, a leader in the Royal College of Pathologists, explained the policy of concealing the common practice of removing organs as “an attempt to avoid distress” to the families concerned. “I don’t think anyone has been *consciously* arrogant” he is quoted as saying (Goodchild, 2000, emphasis added).

Anecdotal evidence gathered by me during the course of this research suggests that those in the junior professions such as nursing who regularly work alongside doctors, particularly in the hospital setting, still recognise the description of the arrogant practitioner.

These attitudes and traits are in the process of changing, however, it will be many years before the changes filter through to the upper echelons, or driving seat, of the profession. Thus, the ethos of the paternalistic middle-class, middle-aged, white male still largely dominates teaching and practice within the profession. The characteristic moral spirit of the profession, the conviction of its elevated status, is transmitted in medical schools to the next generation of doctors, perhaps unconsciously, by the noblemen of medicine, the “old boys” who are still very much part of the profession. It is still true to say: “Every medical society and medical school knows them” (Jonsen, 1990, p.68).

Women and The Medical Ethos

Porter suggests that a “modest breach” has been made in what he calls “the chummy, clubby male medical world” by the admittance

of women to medical school. That chummy, clubby world of the medical establishment did not make it easy for women to achieve admittance. Digby (1999), looking at 98 years of general practice up to 1948 noted the “strong opposition of medical faculties” to women entering medical school. Although in the wider social world there was noticeable support for women as doctors, the profession itself was less positive in its response and “concessions on the entry of women to professional bodies and elite medical institutions came very slowly”. In Britain the first breakthrough came in 1879 but it took until half way through the twentieth century before the “last citadel” fell to women (pp.29, 55, 156; cf. Witz, 1992, p.83f).

Even today with women making up more than 50% of the students entering medical school the breach they have made on the traditional medical ethos, both in the medical schools and beyond, has been no more than modest. Just how modest is shown in the results of research of a cohort of medical students undertaken in the late 1980s. Referring to this study, Allen (1997b), notes that women students were treated differently from their male colleagues in being subjected to negative and discriminatory remarks that undermined their confidence, leaving them feeling insecure and uncertain as to their abilities and their place in the medical profession. She concludes that such treatment is “a real indictment of a system that does not recognise or develop the abilities of such...exceptionally talented young women” (p.25).

After qualifying, a disproportionately large number of women remain in the lower ranks of the medical profession. Even in GP practice where it might be thought that men and women were on a more level playing field, research undertaken by Chambers and Campbell (*Doctor*, 1999a), showed that women GPs tended to be less senior than their male colleagues; held fewer posts outside the Practice and were only half as likely as their male colleagues to sit on medico-political committees. Within the Practice, male doctors were more likely to be responsible for minor surgery, computers, Practice finance, and annual reports; whereas female doctors, often against their personal preference, handled more than their fair share of the obstetrics, gynaecology, family planning, child health and counselling sessions. "Women GPs do a disproportionate amount of women's health work and men have a disproportionate amount of traditionally masculine roles" (p.36). The article notes that the results confirm the findings of other similar research.

Women have been, and in large measure still are, viewed as part of the invisible supporting cast whose job is to maintain the *status quo* rather than question it (Davies, 1996, pp.668-671). Historically, any contribution from women beyond this traditional role met with strong resistance (Witz, 1992, p.73ff). This attitude is still evident within the profession, hence, the impact that women can have on the medical ethos, the moral tone that colours all its perceptions, whilst

greater than it once was, continues to be limited (Smith, 1987, pp.17,18,25).

Black Humour and the Medical Ethos

The black humour that is common among practitioners¹⁷ is, as the earlier examples show, part and parcel of medical school life. It is closely related to and springs from a central element of the medical ethos, namely, professional detachment (Collier *et al*, 1995, p.413). The argument is that such humour provides doctors with an acceptable defence against the emotionally draining experience of dealing with the sick and dying on a day-to-day basis; it enables the doctor to cope better with the needs of the patient (Sinclair, 1997, pp.287-288).

Time for counselling, or even de-briefing after an intensive period of witnessing the suffering of one's fellow humans; procedures that are common for other professionals dealing with emotionally demanding situations; are scorned among medical practitioners as self-indulgent and "soft". For the doctor, humour, and particularly black humour, is the accepted and acceptable way of handling the enormity of the suffering they witness.¹⁸

¹⁷A popular example in the medical press is the regular Tony Copperfield column in the journal *Doctor*.

¹⁸Hale (1997, p.34), describes a range of other coping mechanisms including denial of stress, 'acting out', that is "any action that helps avoid something which is painful, though the action itself maybe harmful". He cites "getting pissed" as a common action among medical students. I would suggest that black humour is another common example of acting out.

However, anecdotal evidence suggests that such humour, and similar coping mechanisms, rather than helping doctors cope humanely with their patients can damage both doctor and patient (Hale, 1977, p.33). At worst the humour might be a sign of, or cover for, gross incompetence, but at every level it can lead doctors to a hard-heartedness, and even an inhumanity, in their dealings with the sick, including the unconscious and the dying (Launer, 1999, pp.35,38; Hammond & Mosley, 1999, pp 39-41).¹⁹

Ethics and the Medical Ethos

Studies undertaken by American researchers (Self & Baldwin, 1993) indicate that ethics does not seem to fare well in this kind of environment. The aim of their research was to assess the moral reasoning of medical students in the first and last of their four years in medical school. They found that over this period the normal and expected increase in moral reasoning did not occur. The researchers concluded that the students' "educational experience served to inhibit their moral reasoning ability, rather than facilitating it" (p.154). The researchers also noted that over the four years the students displayed "a significant reduction in moral reasoning variance" as determined

¹⁹ A very recent example came to my attention during discussion of the implications of the Shipman case. Doctor Shipman was convicted of murdering a number of his elderly female patients. One method he used to dispose of potentially damning evidence was to advise relatives to cremate the deceased. This procedure requires the cremation certificates be counter-signed by a second doctor. Discussing this procedure one GP noted that doctors see this routine matter as an easy money-earner and refer to it as "cash for ash".

on a weighted average score, thus indicating "a strong socialising factor of medical experience" (158).

The thrust of this research is to emphasise that ethos and ethics are inextricably linked. Ethos refers to the moral atmosphere or moral climate in which ethical thinking and practice develops; the moral tone that colours the profession's perceptions and responses. This leads to the question, what kind of ethics does the ethos of medicine identified in this section create? Furthermore, in light of demands from the wider society for medicine to endorse particular ethical principles, what impact does the medical ethos have on the application of those principles to everyday practice? I now move onto a full exploration of these central questions.

Ethics in Medicine

What do we mean when we talk about ethics? What does the concept convey? At its simplest, ethics is defined as "ideas about what is right and what is wrong and how we can tell the difference". However, such a simple definition does not take the analysis very far for no sooner have terms such as "right" and "wrong" been introduced than we have already entered a veritable minefield of meanings. Although it might be thought that questions of right and wrong admit of only one clear answer in practice, "ethics is complicated because our morality is an odd mixture of received

tradition and personal opinion” (Robinson & Garratt, 1996, p.5; cf. Parker, 1998, pp.1,2).

Moral principles, belief in some universal value such as “rights” or “justice”, are taken to be the foundation of ethics (Goldman, 1980, p.1). However, any such universal value is not a moral absolute given²⁰ but is itself a value judgement. The reflective process must clarify and question the values that are the foundation of its ethics. “Morality is not to be discovered but made: we have to decide what moral views to adopt, what moral stands to take”. In this statement Mackie (1977, p.106), rejects the existence of something “out there” called morality. Whereas once this assertion would have met with widespread resistance and seen as heretical, nowadays, at least in Western thinking, it is commonly accepted that there is no absolute authority who decides whether something is moral or ethical and something else immoral or unethical. There are now a range of moral frameworks each privileging a particular core value or group of such values (cf. Warnock, 1998).

In relation to medical ethics, Grayling argues that the element that justifies the use of the word “ethics” is the centrality of a relationship: “Medical ethics is appropriately called ethics... because it concerns everything about a relationship - the relationship between

²⁰ Not all would agree, those with a strong religious conviction, for example, may view the values underpinning their belief as God-given absolutes rather than mere cultural constructs. Such is not a widespread view in Western moral philosophy.

doctor and patient - which can be especially sensitive” (Grayling, 1999). Medical ethics is most often discussed within three traditional moral frameworks: deontology, utilitarianism, and casuistry. A fourth, virtue ethics, the oldest normative tradition in Western society, is once again receiving more attention (Beauchamp & Childress, 1994; Gauthier, 1997, p.339; Battin, 1990, pp5-7).

Deontology

This moral theory, arising from the work of Immanuel Kant (Kant, 1783, 1785), focuses on the inherent rightness of an action as against the consequences of the action. Those who adhere to this theory emphasise the duty to do that which is right irrespective of the outcome. A fundamental principle in Kantian thinking is that of treating every person as an end and never only as a means. This principle highlights the moral duty to treat every individual with the respect and dignity to which they are entitled.

Many of the key elements in the GMC’s code of conduct for doctors appear to recognise this principle. They place on doctors the duty to treat their patients with respect and dignity, recognising their intrinsic worth, and requiring their care to be the doctor’s primary concern (GMC, 1995).

Another important aspect of the deontological approach, particularly as espoused by Kant, is that it focuses on resolving ethical questions by reasoning around key established moral

principles. This emphasis has had a considerable influence on the formal teaching of medical ethics within the UK (Boyd, 1987, p.86).

Utilitarianism

In the field of public policy- and decision-making the guiding ethical theory is usually some form of utilitarianism.

Utilitarianism, a moral theory usually credited to Jeremy Bentham (1823), is generally recognised within the field as one particular moral theory within the broader consequentialist, or teleological, school of moral thinking.²¹ No moral principle is applied rigidly, but always in such a way as to achieve what has been determined within the moral framework as the best outcome. In the case of utilitarianism itself that outcome is the maximising of utility, happiness or pleasure, with the emphasis on the utility of society at large rather than that of just a few individuals (Haryr, 1994 p.1). As Goodin explains:

when our actions will affect various people in various different ways, it is the characteristically utilitarian conclusion that the right action is that which maximises utility summed impersonally across all those affected by that action....That is the standard that public policy-makers are to use when making collective choices impinging on the community as a whole” (Goodin, 1993 p.245).

²¹ There are those, for example Elizabeth Anscombe, who argue that utilitarianism is not always and only consequentialist. However, this is a minority view and need not concern us in this analysis.

Today utilitarianism takes many forms. The essential characteristic feature, a focus on calculating utility, aiming for the greatest happiness or good in moral decisions, is common to all. However, the other essential principles for determining how that utility be defined and the overall calculation made, differ markedly. Every new formulation is an attempt to correct a weakness or imbalance in the existing versions of the theory (Haryr, 1994, p.46). Thus, Haryr in his recent study of the subject not only looks at the development of modern utilitarianism but then attempts to correct what he sees as a widespread misunderstanding of contemporary utilitarianism. In Haryr's view this misunderstanding has made it impossible to reconcile utilitarian theory with the demands of justice. In addressing these issues he, in turn, develops his particular version of liberal utilitarianism (pp.83,104-127). In light of his special interest in medical ethics Haryr's analysis is significant.

However, in relation to ethics in medicine the GMC's guidance to doctors on good medical practice makes only one reference to a utilitarian principle. In section 3 it is stated: "In providing care you must...pay due regard to efficacy and the use of resources" (GMC, 1995, p.3). Clearly it is up to the doctor to determine what "due regard" actually means in the context of their primary obligation to the individual patient and the responsibility "to give priority to the investigation and treatment of patients solely on the basis of clinical need" (p.9).

Despite this apparent lack of enthusiasm for the utilitarian position by a leading body within the profession, in the thinking of many involved in issues of health care rationing, an increasingly problematic area within publicly funded health care provision, utilitarianism must be given a far higher priority in the relevant decision-making process. Within the utilitarian framework a public policy for the provision of health care must be formulated not on the principle of the individual patients and their good alone, but rather on the needs of the society as a whole, the aggregate, that which is best for the group (Mooney, 1992, p.86ff). The NHS was founded on the principle of collectivism - a utilitarian ethics - whereas medical practice is by tradition highly individualistic. This, as will be seen in the interview data, has presented doctors with an ethical dilemma.

Casuistry

This is the fore-runner of the modern case study approach (Arras, 1991, p.26). It is a system of arriving at ethical answers to moral dilemmas by focusing on the particular circumstances arising in each case, rather than a precise set of principles applicable to all cases.

Casuistry acquired a negative reputation during the Reformation when it was popularly characterised as a system designed more for finding a series of rules for the evasion of obvious moral duties than for finding and pursuing the right course. Hence, the definition of casuistry as quoted from the Oxford English Dictionary (Jonsen &

Toulmin, p.238): "a quibbling, evasive way of dealing with difficult cases of duty; sophistry".

However, it is now increasingly recognised that the casuistic approach is relevant to the resolution of difficult cases arising in, for example, medicine where it is often not possible to arrive at definite all-encompassing conclusions. In such circumstances casuistry enables:

the analysis of moral issues, using procedures of reasoning based on paradigms and analogies, leading to the formulation of expert opinions about the existence and stringency of particular moral obligations, framed in terms of rules or maxims that are general but not universal or invariable, since they hold good with certainty only in the typical conditions of the agent and circumstances of action (*ibid.* p. 257).

The casuistic method allows the identification of a range of possibilities where no single, clear, and specific answer to an ethical problem is available. As Preston observes "casuistry involves recognising the ambiguities of choice" (Preston, 1991, p.94).

By its use of case studies taken from real-life, it enables students to appreciate fully the ambiguities and complexities that face the modern medical practitioner. Indeed, Arras, a Fellow of the Hastings Center (*sic*) and Professor of Bioethics, argues that it is only when real case studies are used that the casuistic method is effective. He advises "make them long, richly detailed, messy, and comprehensive"

(Arras, 1991, p.49). Hypothetical cases, still often seen in textbooks and anthologies, cannot reflect the degree of complexity, uncertainty and ambiguity encountered in the real world.

However, the argument that one of the great strengths of the casuistic method is that it is theory-free, not tied down to any particular theoretical framework, and therefore able to allow the student to work from practice to principles, is quite erroneous. Some set of principles always inform a line of ethical thinking, “once unveiled these principles will turn out to be heavily theory-laden”. It cannot be otherwise, for casuistry is an “engine of thought that must receive *direction* from values, concepts and theories outside of itself” (*ibid.* p.41, italics original).

Principles left implicit in the form of, for example, an unrecognised and unquestioned world view or habit of thinking, will nevertheless have an influence not only on the way an issue is resolved but even, and perhaps more importantly, on the way the issue is understood and addressed. The resulting deliberations and decisions may simply reinforce the established preconceptions of the dominant voice in the decision-making process (*ibid.* pp.38-39). This again emphasises the importance of recognising and understanding the influence of the medical ethos on medical ethics both in thinking and practice.

Virtue

Traditional virtue ethics focuses on the development of the agent as a virtuous person; a person of moral character. "The character of the actor is potentially the wellspring of the act" (Whetstone, 1998 p.187; Slote, 1997, p.177). Thus, a good doctor is a virtuous doctor; a doctor of moral character. This tradition has its roots in the thinking of Aristotle, who defined virtue as that which is undertaken "at the right time, on the right occasion, towards the right people, for the right purpose and in the right manner" (Aristotle, 1106b 20). All ethics was virtue ethics. Within the past few decades there has been a revived interest in virtue ethics with the work of modern Aristotelian philosophers such as Anscombe (1958), and MacIntyre. MacIntyre emphasises the importance of community for the development of the virtuous character (MacIntyre, 1985, pp.155,156). Ethical thinking can never simply be external, a mere "add-on" issue-based bioethics brought in to deal with particular situations identified as ethical dilemmas, but must be internal, the result of a habit of ethical behaviour acquired and developed from the moral tone, or ethos, within a community (cf. Simmons, 1997 p.144ff).

Historically medical oaths and codes are strongly virtue-based focusing as they do on the character of the physician (Ruddick, 1998). The "implicit ethics of practice" that I discuss in this thesis is a form of virtue ethics. The pervading moral spirit, or ethos, of the

profession creates in practitioners attitudes, behaviours, and habits of thinking that within the profession are “accepted as “good”” (Loewy, 1997, p.347ff). Loewy objects to the new emphasis on virtue ethics, arguing that it moves the focus of ethics away from solving problems and towards forming character. But this thesis explores the idea that via its ethos a profession explicitly aims to form the professional character with its professional “virtues” (*ibid.* p.348).

Having defined what is meant by the ethos of medicine, and highlighting the range of theories of ethics common in discussion of medical ethics, it is now time to unpick the another element that has played a major part in creating the ethos.

The Role of Myth²²

Positive Role

Jonsen describes the world of medicine as one “in which the ideas and beliefs formed by myth and tradition are...more powerfully present than the pallid propositions of philosophical ethics” (Jonsen, 1990, p.4). Another writer on medicine and theology has categorised the belief that doctors put patients interests above all others as one of “mankind’s basic religious and familial myths” (Szasz, 1988, p.2). Myth has an important place in medicine and it is appropriate at this point to spend a short while looking at that place.

²² In Barthes’ *Mythologies* myth is defined as a socially constructed reality which is passed off as “natural”. This, suggests Tony McNeil of the University of Sunderland, is close to Eggleton’s definition of ideology as a body of beliefs and representations that sustain and legitimate current power relationships (Eggleton: 1991 pp.5-6). Thus he argues that ‘myth’ and ideology’ work in very similar ways.

It is well recognised that there is a powerful link between ethics and myths. Thus, Wiener argues that without myth-creating, society loses its focus and “the ethical systems, representing internalised transpositions of these myths” lose their hold (1978, pp.20, 27).

In her account of the development of ethical thinking Midgley draws another link. She refers to “a series of powerful myths” filling the gap between the reality of moral thinking and the questions of when and how our ability to think morally arose. She then goes on to explain the way myths work:

Myths are not lies, nor need be they taken as literally true.

They are symbolic stories which play a crucial role in our imagination and intellectual life by expressing the patterns that underlie our thought (Midgley, 1994 p.109).

Myths “catalyze, organize and orientate man's endeavours and his relations to society” (Wiener, 1978, p.25). In Feyerabend's phrase they are, “the poetic imagination, which grasps human life as a whole and gives it meaning” (Feyerabend, 1987, p.21; cf. Nussbaum, 1986, p.213). Explaining Plato's concept of the “magnificent myth” Wiener notes that:

society depends on the magnificent myth... for creation of societal cohesion and commitment, and for acceptance of those constraints upon the freedom of the individual without which society cannot exist and progress (Wiener, 1978, p.162).

Myths are thus far more than mere fanciful illusions; the naive stories of our primitive ancestors. They represent symbolic systems that are an essential element in the making of a society. As Nussbaum emphasises, myth-stories may not be literally, historically true but they can express metaphorically a deeper truth. The notion that myth can be ousted by facts, reason, and logic is itself a naive illusion (Nussbaum, 1986, p.209; Wiener, 1978, p.170; Midgley, 1994, p.117²³). Standing between and beyond the mere story and the scientific, objective²⁴ explanation of how the world operates, mythology interprets our world with its use of powerful and familiar images concerned with kinship and status. In the words of Solomon (1993, p.151), it “interprets and selects, edits and personifies, aggrandizes (*sic*) and dramatizes (*sic*), our Reality and gives it meaning”. Failure to recognise the potency of the myth and, therefore, its role in the modern world, prevents us gaining a full understanding of the way social structures and the ethical systems that govern their operation are created and maintained.

²³ There is the suggestion of some confusion as to the meaning of the concept ‘myth’ in Midgley’s analysis. On the one hand she sets out the role of myth as follows “Myths are not lies .. they are symbolic stories which play a crucial role in our imaginative and intellectual life by expressing the patterns that underlie our thought” (Midgley, 1994, pp.109, 117). At other times she appears to fall into the popular misconceptions. Thus, she contrasts myth with “genuine scientific evidence and principles” and “genuine biological theory” (Midgley, 1991, p.5). The implication is that now we have the genuine scientific biological facts the “emotive symbolism” of the myths can be discarded.

²⁴ Regarding objectivity the following comment subtly draws out the relationship between objectivity and myth: “The notion of objectivity...even nominating it as an ideal is clearly founded on the belief that things are separable into the real and the fabricated, and that it is possible to see the real with an eye innocent of symbols or interests” (Durham & Rothenbuhler, p.15).

Negative Role

This positive view of myth sees its function as directing, energising, and motivating a community. "Goal-myths originate the vital needs of nations or other social groupings". Wiener also notes that, "while couched in mythical symbolism, they still have their roots in specific contemporary political, economic, social and psychological needs and wants" (Wiener, 1978, p.50). This link means that myth can also play a more invidious role in establishing a world view. Here the myth arises from a highly selective version of "the facts" and beyond that outright falsifications. Through such myths one section of society can be presented as in some significant way superior to another and therefore morally justified in exercising control over those groups it views as inferior.

Watts (1997), offers an interesting example of the way that negative myths can operate in the field of medicine. During the age of European and North American imperialism the myth of Development along with the pseudo-scientific doctrine of Social Darwinism was used to justify the exploitation of the "new" territories. In this context Watts notes that:

Coming out of the scramble for Africa, the scramble for China, and the conquest of Spain's old empire...by the USA was the new discipline of Tropical Medicine. From its very onset tropical medicine was thus an "instrument of empire" intended to enable the white "races" to live in, or at the very least exploit, all areas of the globe. [After all] Europeans were

at the very summit of the evolutionary chain and... they should, by right, dominate all other humankind (Watts, p. xiii).

What part these elements, in both their positive and negative forms, have played in constructing the medical profession's ethos and the ethics identified with it, is the focus of the next section.

Myth, Ethos, and Ethics

The Hippocratic Oath

Over the years, the medical profession has built a powerful coalition between itself and the people, “where the concerns voiced by the...profession are virtually identical to those expressed by the general public” (Harrison *et al*, 1992, p.102). This concord has been formed, in part, because of the widespread perception among the populace of medicine as an inherently ethical profession. Everyone “knows” that doctors are bound by The Hippocratic Oath and are, therefore, trustworthy. Doctors themselves are certainly not averse to reminding the public of their Hippocratic pedigree. A Regius Professor of Medicine has observed that: “The famous Hippocratic Oath...still offers an ethical framework for those few doctors who are familiar with it” (Weatherall, 1995, p.28; cf. Lee-Potter, p.123²⁵).

²⁵ Lee-Potter describes a “sinister” document produced by Trent Regional Health Authority in which the following statement occurs: ‘If a self-governing trust values teamwork - it needs to confront the obstructive and the prima donna when all else has failed to persuade individuals to sign up to a corporate philosophy’. Lee-Potter then notes: “My response to this was: ‘I think we have a corporate philosophy in medicine and that it has *something to do with Hippocrates*’” (emphasis added).

It will be instructive to take a closer look at that well known code of conduct for doctors. Whilst the popular imagination might see each new doctor standing before an august body of her or his peers and repeating the Hippocratic Oath before being allowed to go forth and practise, the reality is rather less significant as witnessed by Sinclair, when a second year medical student. Toward the end of the introductory lecture, after many of the senior members of the faculty had departed, first year students were invited to repeat the oath:

A small transparency of the Hippocratic Oath was then projected on the screen, so small it was nearly illegible from the back of the [lecture] theatre. This was recited slowly, at first, everyone tried to follow and read it aloud, but gradually the new students gave up, leaving only the planted clique of second years (1997, p.99).

While it is from this ancient Oath that modern medical ethics finds one of its four principles, namely, *parum non nocere* or first do no harm, in its few specific injunctions, the Oath is at variance with significant elements of standard modern medical thought and practice. Those bound by the Oath specifically promise: “I will not give a fatal draught to anyone who asked”. Today the advised ethical position on euthanasia is much less clear as Beauchamp and Childress’s textbook on bioethics shows. It offers the argument that: “merciful physician interventions in the form of voluntary active euthanasia are not inherently wrong or incompatible with the role of

a health professional” (1994, p.227). In like manner, the Oath requires doctors to promise: “neither will I give a woman means to procure an abortion”. Today abortion is a widely accepted, even common, medical procedure (Garcia, 1997, p.161).

One element of the oath, that involving the correct attitude toward colleagues, and particularly seniors, although eschewed by the modern GMC’s code of practice is still very important in governing the relationship between professionals. The Hippocratic Oath emphasised that respect was due from the apprentice physician towards his teacher. Thus: “I will pay the same respect to my master in the Science as to my parents”. This emphasis codified the strong collegiate bonds between the “brotherhood” of doctors and led to the notion of “closing ranks” to protect a colleague from outside criticism (Strong and Robinson, 1990, p.35). That emphasis has continued down through the centuries. Percival’s *Medical Ethics* written in 1803 “concerned itself mainly with intra-professional demarcation or medical etiquette rather than standards of moral behaviour by doctor towards patient” (Digby, 1994, p.59). Although the current code of conduct for doctors tells them that they must put the welfare of their patients above the interests of colleagues, “a doctor must act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise” (GMC, 1995), the Hippocratic emphasis continues to underpin the day to day reality of the doctor-doctor relationship. As

one doctor, now the editor of the *Lancet*, recalls from his medical training in the early 1980s:

Doctors learn to keep other doctors' mistakes secret from almost the first day they arrive in medical school. It is part of what being a profession is all about (Horton, 1998).

A considerable body of anecdotal evidence exists to show that when colleagues have reason to suspect that the clinical practice of a fellow practitioner is faulty, and even potentially dangerous, there is a marked reluctance to expose this situation. Not only is an understanding "blind eye" turned to doctors who are simply incompetent but also to those with serious drug or drink problems and evidence suggests that 1 in 15 doctors have such problems.²⁶ Even when a doctor is brought before the GMC the procedures, according to one lay observer, seem more designed to cover up the "misconduct" than to protect patients from harm (Robinson, 1988, pp.37,41). Hammond (1997), quotes recent research suggesting that: "the GMC is six times more likely to discipline an ethnic minority doctor than a white doctor". He then notes: "This is not due to a persecution of ethnic minority doctors, but rather because white doctors are far more likely to get away with misconduct".

²⁶ Information from a broadcast on Independent Television, February 9th 1998. The programme also suggested that among the pressures that drive doctors to these addictions is the moral/ethical conflict arising from the expectations they know the public have of them and the reality of what they are able to deliver.

Thus, the Oath seems to present modern medicine with something of a dilemma. On the one hand “the Hippocratic tradition...has turned out to be a limited and generally unreliable basis for medical ethics” (Beauchamp & Childress 1994, p.25), yet doctors themselves adhere in practice to one of the least helpful principles, that of loyalty to colleagues. Furthermore, even though Beauchamp and Childress note the Oath’s limited value they still choose to point back to it as *indicating a distinguished pedigree*. Thus, “an obligation of non-maleficence and...of beneficence are both expressed in the Oath” and “requirements of confidentiality appear as early as the Hippocratic oath” (Beauchamp & Childress, 1994, pp.189,418). Finally, to the patient the Hippocratic Oath is the ultimate indication of the doctors’ professional rectitude; the paradigm of medical ethics. Efforts to resolve the dilemma by “restating” the Hippocratic Oath have not had the same mythological impact on public or professional consciousness as the original.

Ethics in the Medical Curriculum

Beyond talk of the Oath, until the last 15 years or so, ethics was not considered important enough to have a place in the curriculum of most medical schools. ten Have (1988), points out that before the 1960s, ethics was not often discussed in the medical literature and that it is only since the end of the 1970s that the importance of analysing moral dilemmas in health care practice has become

recognised. Even that assessment might be somewhat optimistic as the Reith Lecturer speaking in 1980 observed:

We should...expect that doctors have some educational grounding in ethical analysis. To suggest this....crucial point is to invite scorn. 'There is no room in the curriculum.' My response is that...ethics must be a central course (Kennedy, 1983, p.97).

In the assessment of one senior medical tutor, medical ethics has only come of age in "recent years" in terms of its inclusion in standard medical curricula (Goldie, 2000, p.109).

Although this situation is now changing, the change is gradual and then only for younger doctors and those currently in training. In an address to the Office of Health Economics given by Professor David Sackett on the subject of evidence-based medicine, the Professor began by explaining that he was neither a student of ethics nor health economics and that his "knowledge in these areas is mundane". The ethical principles guiding his decision-making arose "through an iterative process" having been defined retrospectively "rather than prospectively as a starting point for determining my values" (Sackett, 1996, p.3).²⁷

²⁷ A few years ago, I was one of a group of MA students invited to meet and talk to a consultant in the field of *in vitro* fertilisation (IVF). All the audience were preparing dissertations on some aspect of medical ethics. IVF was a subject that, in our view, raised a number of ethical concerns and we were eager to hear the consultant's view on these issues. However, just before the meeting we were advised not to ask "ethical" questions. The consultant, a young man, had told the Course Director that he would not be comfortable with such matters and was only

Even doctors who have gone through the recently introduced ethics training are still apparently ill at ease with the idea of “exploring the tensions and conflicts between ethical principles and suggesting ways of resolving them” (Kennedy, 1983, p.97). Thus, Grundstein-Amado (1993), found, in a study that included 50% doctors, that clinical-ethical “decisions were made in a narrow, habitual manner, through the elimination of the most significant and demanding elements of the process”. And, whilst fifth year undergraduates in the medical school of the University of Sydney responded positively to their medical ethics teaching programme, “a number complain[ed] that simple answers to common problems [were] not provided”. This, despite the fact that the teaching programme had been designed to “raise awareness of the complex nature of decision-making and to encourage students to determine their own moral viewpoints to common controversial issues (Hays & Molodysky, 1993, p.40).²⁸

These findings call attention to a paradox that requires further investigation. For many years the profession did not consider ethics important enough to merit inclusion in the medical schools’ curricula and even now that it has been included doctors still appear to be uncomfortable with the responsibility of identifying, let alone

prepared to speak on his specific subject. to describe and discuss the technical details of the various IVF options.

²⁸ Although one UK ethicist observes that in her personal experience of teaching medical ethics to nurses they did “not expect philosophy to give them answers: merely to teach them to ask the right questions” (Dickenson, 1989, p.109).

resolving, ethical tensions within the clinical setting. Yet, at the same time the profession presents itself as, and is widely perceived to be, firmly set on the high moral ground, under-girded by clear ethical principles. Understanding the nature of the link between the medical ethos and medical ethics, encapsulated today in the four principles, resolves that paradox.

Freidson (1970), notes that the so-called “consulting profession”, those dependent on “popularity with laymen (*sic*)” (p.73), have to offer reassurance to their prospective clients. The “cosmetic” (p.83) of a code of ethics is a central element in attracting and reassuring their target groups (p.186). In his history of the medical profession Bullough describes how the role of ethics was developed as medicine worked to gain status as a respected profession.

Beyond the Ethical Dilemma

The practice of medicine involves an exercise of power. Kennedy, in a study that focused on the power of the professional, observed that “the monopoly power to confirm or deny the presence of illness rests with the doctor” (Kennedy, 1983, p.7-9). Linked to this power “there are a certain set of roles and privileges that we have come to conceptualise as inherently linked to the doctor....They....give the orders. They are...in charge” (Lantos, 1997, p.6).

Bullough sets out the steps by which the modern, orthodox, medical profession came to its position of pre-eminence (Bullough, 1966). In so doing he makes clear the link between knowledge, power, and ethics. After noting the modern passion for pursuing professional status, he observes that: "The group which has often served as the norm by which all other professional groups are judged is that of medicine" (p.3). There then follows an absorbing account of how medicine developed as a profession. One aspect identified as essential to this development was the emergence of the university and the successful move to exclusive university accreditation for medical training.

According to a leading member of the profession, the system in Europe that required the attainment of a university degree served as a protection to the public. "The granting of licences was developed as a device to distinguish (properly educated and qualified practitioners) from, non-professionals" (Hoffenberg, 1987, p.4). However, a university education did much more than protect patients; it protected and enhanced the status of the individual practitioner and the developing medical profession as a whole. Thus, it "prepared the graduate to move in genteel society; a medical education at Edinburgh, Oxford, or Cambridge opened doors to the wealthy patient" but at the same time reassured those wealthy patients "that the practitioner had no overriding pecuniary interest in their treatments". Furthermore, "an appearance of gentility tended to

reinforce medical authority” (Digby, 1994, p.59). And “the more the university dominated the field, the more clearly medicine maintained its professional grip” (Bullough, 1966, p.109). Freidson (1970, p.51) states that “university training gave physicians and surgeons a stronger political position for persuading the state to subordinate to them such competitors as apothecaries, grocers, and barbers, not to speak of allowing them to prosecute the irregular practitioners”. It was, and continues to be, for the profession itself to determine who is an “irregular practitioner”.

Medicine had achieved the status and attendant power of a profession by circumscribing what constituted medical knowledge and then closing off that knowledge to all but those educated within the university. Now arose the need for a code of ethics:

A code of ethics is an important device for persuading the general public to believe that members of an occupation are ethical (Freidson 1970, p.186).

Bullough points to the two different roles such codes had to perform requiring that they be couched in somewhat contradictory terms:

By definition a profession has to have some sort of ethic, the rules of the game which each practitioner attempts to follow....To persuade the public to accept these exclusionary tactics of the university trained practitioner, the need for regulation had to be couched in terms of *ideals* (what Bullough

had earlier termed “pious sounding statements” p.4), but to gain the support of the would-be professional it was necessary to emphasise *self interest*....The result was a growth in medical deontology, a growth which coincided with institutionalisation (Bullough, 1966, p.93, emphasis added).

Tadd, in his look at professional codes of ethics, asked what function is a code of ethics meant to perform and whose benefit is it meant to serve? In reply he quoted Richard Hull: “the practice of generating codes as self-regulating devices can be seen....as *devices for insulating a profession against unwanted incursions* by affected parties or groups who may dissent with some of the historically or currently favored (*sic*) features and traditions of that profession” (Tadd 1994, p.16, emphasis added). Such codes are the means of persuading the general public of the probity of members of the profession, or more generally of justifying whatever the profession considers it necessary to justify in order to maintain its position, particularly its autonomy, that is to say its freedom to “give orders to all and take orders from none” (Freidson, 1970, pp.186,70; Bullough, 1966, p.93).

However, to maintain their exclusive rights to practice, medical practitioners had to seek “support from the state”; from kings and popes; the power bases of the day. “A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is

some special value in its work” (Freidson 1970, pp.47, 72). Foucault (1973), asserts that in due course the state found its own use for the profession as one of its “soft” control systems for maintaining an orderly population. The “clinical gaze” became another element in the State’s “panoptic system of surveillance” (pp195-228). Through the intensification of medical power, the State was able to exercise what Armstrong describes as a “politico-medical hold on the population” (Armstrong, 1983. p.147). Thus, medicine and the state formed a mutually beneficial partnership; the medical profession using its power to help maintain public order; the state using its power to bolster and sanction with law the profession’s exclusivity. By entering into this partnership medicine was also submitting itself to the control of the state. Autonomy was not absolute but limited by the political power to which it owed its existence (Freidson, 1970, pp.23ff, 369).

Williams and Calnan (1996, p.8), consider the Foucauldian perspective too simplistic due to its failure to take account of evidence of opposition, criticism, and resistance to medicine among the lay populace, at least within the contemporary era. Whether or not the lay populace is less passive and docile than it once was is somewhat irrelevant, although Armstrong (1983), certainly considers that submission to control under the clinical gaze was evident well into the mid-twentieth century at least. Szasz (1988), presents strong evidence in support of this view particularly in the case of psychiatric

medicine. "Medicine does not merely operate in conjunction with the state; in modern industrial societies, medicine is actually a part of the state - it is a sort of state religion... The state supports and legitimizes (*sic*) medicine, and medicine in turn supports and legitimizes (*sic*) the state" (p.146). Foucault's contention that the state saw medicine, the medical gaze, as a suitable method of population control and surveillance is valid. The medical profession was and continues to be offered protection and legitimacy by the state and in return the state sought and seeks to use the profession in its public control structures. A mutually beneficial arrangement (cf. Allsop, 1995, p.16-17).

In her analysis of the impact of professionalism on nursing, Salvage (1985), offers the following assessment:

The assumption that professionalism means excellence is often used to justify the profession's position of superiority. They say they are protecting the public by controlling recruitment and training...A critical look at the occupations usually defined as true professions, such as medicine,.. reveal some worrying facts. For example, the reasons for restricting entry to the profession often seems to spring, not so much from a concern for public welfare, as a desire to stop others muscling in on a profitable job....The attempt to win recognition and the attendant material benefits for a select group inevitably excludes others and insisting on strict control of entry and

education and therefore knowledge denies it to others, not least the patients themselves (Salvage, 1985, pp 89,95).

Perhaps the less than noble motives identified by Salvage and illustrated in Bullough's history of medicine's journey to status of senior profession, offers an explanation for the durability of the outdated Hippocratic Oath. The Oath and the beliefs surrounding it are an essential part of the profession's mythology, a story that has been passed down to generations of doctors and patients. It plays its part in softening the sharper edges of the "reality" of medical practice thereby enabling practitioner and patient to play their respective roles in the equally myth-imbued doctor-patient relationship. Trust in the doctor is still a vital element in that relationship (Little & Fearnside, 1997). No one wants to give themselves to the care of a greedy, manipulative professional, rather they want to believe that the doctor in front of them is part of an honourable profession, rooted in a centuries-old ethics of care and commitment to the well-being of their patients.

Digby (1999), describes this conflict between myth and reality in her account of the difficult path GPs of the 19th century had to tread. General practice was an uncertain profession, survival could be a struggle so it required of the GP "distinctive entrepreneurial and organizational (*sic*) skills". However, too open a display of such business skills resulted in "criticism and a loss of prestige" and hence income. The myth of the family doctor was already established and

the public expected those “mythologized” (*sic*) creatures to display “the steadfast virtues of professional dedication and disinterested concern for patients” (pp.97,100). The Hippocratic Oath is the epitome of that faith and medicine is, understandably, happy to let it be so.

However, whilst faith and myths have a vital part to play in validating and maintaining the social order, including perhaps the relationship between doctor and patient, “they can”, as Pattison points out, “if *unexamined* and *uncriticized*, act ideologically to impede reflection and inhibit emancipation and fundamental change” (Pattison, 1997, p.53, emphasis added). In this study a critical examination of the myths of the medical profession has led to a more informed understanding of its ethos. Without such an understanding the changes currently being called for from the medical profession will be less likely to achieve their intended goal.

Linked to the myth behind the ethos are the values informing both ethos and the ethics arising from or interpreted by the ethos.

Values in Ethos and Ethics

“Values” are central in any ethical framework, they also lie at the heart of the medical profession’s ethos. The nature of their contribution to ethos and ethics, both explicit and implicit, will now be explored.

The term values falls into two very distinct areas of use. In economics the meaning is clear and precise. Thus, “value in use” refers to the pleasure a commodity actually generates for its owner while “value in exchange” means the quantity of other commodities a commodity can be swapped for, most commonly the amount of money the consumer is prepared to pay in order to purchase the desired commodity (Bannock *et al*, 1987 p. 415; cf. Cole, 1995, p.127,130).

However, it is values in the context of objects judged to be worthy of human pursuit that makes the term relevant to this study of the relationship between ethos and ethics. Hence ideals, motives, sentiments, and actions can all be considered to have value. But in all these instances the values must be linked to an individual or group; they are always someone’s values. Within this realm such judgements can be either in terms of obligation and what ought to be done, or of worth, goodness or intrinsic desirability (Scruton, 1983, p.483; Ladd, 1983 p.378).

Despite the seeming clarity of this general definition, the word is nevertheless, used so broadly, and even carelessly, that in Scruton’s phrase, “it generates more questions than it answers”. Thus, even in what has, rightly in my opinion, been described as a classic work on professional ethics (Battin, 1990, p.271), the author refers to “the fundamental values and norms of each profession” (Goldman, 1980, p.24). He thus uses these two words interchangeably thereby

suggesting that values are synonymous with norms. But just two paragraphs later he appears to use “interests” as a synonym for values. Even when he moves on to discuss a theory of value he does not consider it necessary to clarify precisely what he means by the word. Of course, it is reasonable to assume from the context that Goldman is not using the word in the economic sense. But beyond that it is not clear exactly what he means by values. The reader is left to glean the meaning from the range of uses throughout the work and this can lead to some confusion.

Goldman appears to assume that his readers will know what the word values means. And perhaps, in the context of the subject matter, he is right so to do. On the other hand, he may simply have fallen into the common trap of believing that as it is a word we all use many times it must be well understood. Little’s observation on the word “trust” is equally applicable to “values”: “It is one of those words whose meaning seems so transparent to us that we never notice that it means *different things in different contexts and different mouths*” (Little *et al*, 1997). In the case of values this is a misplaced confidence, for whilst the word may be widely used, its meaning appears to be poorly understood.

The amorphous character of values has been commented upon as follows: “the notion of value and values can happily slip, chameleon-like, between users and utterances, delighting all and offending none because most people do not take the trouble to think

about what it actually means in their own lives or those of others” (Pattison, 1998). In fact, it is this very catholicity and all-inclusiveness that has given the liberal model of ethics its appeal. Within this framework “almost anything the people want can be counted as a value” (Ladd, 1983 p.378).

While certain values such as truth-telling can rightly be viewed, almost without question, as moral principles, many other values are no more than the interests and prejudices of a particular group. If the group involved has considerable influence and power within a particular society, those values may even become the ethical standards required of the wider society over which the dominant group holds sway. The values of one section of a society are taken to be the values of the society as a whole (Szasz, 1988, p.3). Thus, Sherwin, along with many feminist writers, see medical ethics as an extension of the values of a male-dominated society. In her study of traditional medical ethics Sherwin calls them, “blatantly misogynist values” (Sherwin, 1992, p.43), that have worked against the best interests of women and other oppressed groups.

This perspective meant that the health problems experienced by women were believed to be the result of some fundamental imperfection, some weakness, of the female body and mind. Thus, for the treatment of the ultimate female illness, hysteria, doctors recommended suffocating the hysterical woman, beating her across

the body and face with wet towels, and finally shaming her into repose with ridicule (Ehrenreich & English, 1979, p.125).

Even the Porters, while rejecting much of the feminist interpretation as overly pessimistic, recognise that some of the treatments doctors considered appropriate for women were “appallingly sadistic” (Porter & Porter, 1989, pp.175,179-180). Women still find the attitude created by these negative images of their health needs pervading much of the health care they receive (Holmes, 1992, pp.1-8; cf. Sherwin, 1992; Lupton, 1994, p132-138).²⁹ Specifically in the field of medical ethics the particular issues defined as “ethical dilemmas”, the way the questions are addressed, and the particular solutions offered, although “clothed in a cloak of neutrality” tend to focus on masculine values of power, status, and authority thereby excluding from the debate the experiences, perspectives, and values of women (Warren, 1992, p.33-35).

For that reason Bowden (1997, p.2), after condemning “the morally repugnant biases produced by a tradition that persistently favours interests associated with men at the expense of those characteristically ascribed to women”, is moved to devise a code of ethics that, she believes, takes full account of and reflects the values and interests of women (cf. Grimshaw, 1993, p.491f).

²⁹ ‘Beloved Image’ in Nelle Morton’s *The Journey Is Home*, Boston, Beacon Press, offers a challenging, sometimes even disturbing, account of the impact of negative female imagery on both male and female attitudes and thinking and one group of women’s efforts to alter that negative imagery.

A powerful group such as the medical profession may also demand and be granted the right to a set of values that conflict with those imposed on or accepted by the wider society. This is the element of medical ethics explored by Goldman.

What he calls Strong Role Differentiation involves a profession claiming special rights with regard to “what would otherwise be morally overriding”. Professions may demand either that their own values “be weighted more heavily than they would be against other principles in other contexts” or that they must be allowed a unique set of ethical principles. The values central to the profession have to be given special or overriding consideration “in situations in which they might not appear overriding from the viewpoint of normal moral perception” (Goldman, 1980, pp.2,3).

In the case of the medical profession, this approach is epitomised in the claim by doctors to their right to withhold the truth from patients. Information is viewed by the doctor not as the patient’s right but as an element in the doctors treatment programme. Therefore it is the doctor who decides what and how much of such information a patient should be given.

Bok (1989, p.226), identifies what are to the medical mind three essential justifications for their position on truth-telling. All hinge on the principle of “patient’s best interests” as defined by the doctor alone. That principle is the profession’s “overriding” moral value. Thus, they argue that: i) truthfulness is impossible, doctors can be

wrong so why burden patients with information that may prove to be inaccurate; ii) patients themselves do not want to hear bad news; iii) the information may harm patients.

Harris (1994), considers justification on the basis of “doing no harm” a doubtful principle (p.208). Bok (1989), is prepared to accept as valid the profession’s arguments in a “few carefully delineated cases” but considers that a general inclination to deceive or lie to patients undermines the trust that the cared for must have in their carers (p.241). Goldman goes further and rejects completely the justification offered by the profession for deceiving patients.

Despite the concerns and protests raised by, among others, moral philosophers and patients themselves, the medical profession maintains its right to override “the viewpoint of normal moral perception” in order to fulfil what it presents as a *prima facie* duty, that of deciding what is in the best interest of patients, including how much information should be given concerning diagnosis and prognosis.³⁰

³⁰ In “Tell me the Truth, Doctor” a “Heart of the Matter” programme broadcast on 7th February 1993, a consultant cardiologist Jane Somerville described her rights as a doctor in this area. “Just as part of my training is to decide what is the right operation...another part of my training is to decide what patient[s] can accept being told...If for instance somebody is a simple person (a judgement she as a consultant cardiologist felt competent to make), I don’t think they want to hear all the difficulties and all the technical details. That’s a right I’ve taken - to judge that I mustn’t tell them. If you have a very intelligent person who’s trying to plan their life...then you must tell that person a bit more”. (See transcript of broadcast *Tell me the Truth, Doctor*, 1993, BBC Broadcasting Support Services, London). The programme explored what was back in 1993, seen as a growing trend away from medical secrecy and towards more openness, more telling, “giving patients much greater autonomy, much more choice over what happens to them”. It was suggested that medical paternalism was a thing of the past with the new generation of doctors

Two further aspects of this element of the medical character are doctors lack of communication skills and the closely related inability to cope with uncertainty (Katz, 1988). Both are singled out for mention in the GMC's report on educating tomorrow's doctors' and the profession is urged to improve doctors abilities in these areas.

Analysing her own experience of coping with illness Fleischmann recalled that: "One participant in the naming debate candidly stated: "why not be honest with the patient and tell him we don't know"?" She commented: "One can only admire this physician's willingness to be up front with the patients regarding the state of the art of prognosis" (Fleischmann, 1999, p.19).

Whilst an ability to talk openly and honestly with patients may be recognised as an essential skill in modern health care, in everyday practice the honesty which many patients and lay people would consider an essential part of the doctors ethics was and is still much rarer than outsiders might assume or theorists might wish. Within the ethos of the practising medical community it has not been viewed as a matter of great importance, as noted above "dishonesty" is viewed as ethical inasmuch as it is designed to protect patients from undue

much more willing to work *with* patients. However, such is the conservative nature of the medical profession that seven years later David Gilbert, Fellow at the Office for Public Management wrote in an article in the Guardian of 26th Jan 2000, that doctors were just discovering that "at an individual level letting patients take more control of their own health problems can lead to better outcomes". He quoted the response of local GP and HA representative Dr Brian Fisher, to a half day seminar on patient involvement: "It was remarkable. For the first time, patients were saying what they thought worked. And professionals listened".

anxiety and thus, conforms to the doctor's ethical obligation to do no harm. At another level it is also designed to protect the reputation and standing of doctors; they would not wish their patients to consider them less than fully knowledgeable about all matters relating to disease and treatment of disease - thus their unwillingness to admit uncertainty maintains the myth of the expert doctor.

Summary

Despite initial reluctance within the profession to include ethics in their curriculum, modern medical ethics, with its emphasis on patients best interests and the four principles, is now a firmly established academic subject. There are standard texts, numerous journals, and several university departments devoted to the minutiae of the subject. The four principles have become well known and widely discussed. On the other hand, ethos remains virtually a lost concept - subsumed by its now fashionable cousin, ethics. Thus, discussion of the nature of the medical ethos and its influence over the application of the ethical principles to every day practice and decision-making is overlooked. Yet, whilst the teaching of ethics has now moved into the mainstream of medical education it is the ethos taught in, or rather absorbed from, the "hidden curriculum" that continues to influence the profession's attitudes and actions (Goldie, 2000, p.117; Edgar, 1995, p.151). The aim of this chapter has been to pull ethos out of the shadows and, by looking at the central myths

and key values of the medical profession, begin to explore its quiet but telling contribution to the everyday application of medical ethics.

The next chapter looks at the profession's ethos in action. I explore the history behind both the opposition of the general practitioner arm of the medical profession to the creation of the NHS and the attitude of the profession as a whole to the *management and control of the Service*.

Chapter 3

Battle for the NHS: Altruism and Self-interest

There are numerous histories of the NHS. The historical material for this chapter has been drawn from a wide range of standard texts including Abel-Smith (1979), Eckstein (1958), Klein (1995), Timmins, (1996), Pater (1981), Webster (1988, 1996, 1999), and Berridge (1999).

In 1948 the National Health Service came into existence and the medical profession strongly opposed this development. In 1989, steps were taken to reform the Service with the aim of making it more efficient. These reforms were again met with opposition from the medical profession. In both cases the profession presented its opposition in terms of ethical principles, in particular its obligation to protect the interests of patients (Webster, 1999, Berridge, 1998; Allsop, 1995; Klein 1995, Lee-Potter, 1997).

Jonsen (1990), highlights self-interest and altruism as one of the central paradoxes of modern medical practice. The perspective of this study translates that paradox into the difference between, on the one hand, the values endorsed by the old well established ethos and, on the other, the principles of new medical ethics. Thus, the profession stimulates “all the intensity of self-interest” while at the same time on every public and ceremonial occasion proclaiming the altruistic ideal (pp. 12, 13).

This paradox is much in evidence in the events leading up to the creation of the NHS. Viewed through the lens of the distinction between ethos and ethics, the objections the profession raised are seen as informed more by the established professional ethos than the modern medical ethics. This is made even clearer with an analysis of the dissent that arose in the ranks of the profession as the various factions began to question the motivation of those taking a contrary position and cast doubt on “opponents” claims to be acting ethically, that is to say, always in the best interests of their patients.

In this chapter, I re-examine the actions of the medical profession, and its own justification of those actions, as they relate to the creation and subsequent control of the NHS. The words and actions are analysed in terms of both the profession’s motivating ethos and public ethics. In the following chapters the analysis is applied to the responses of the profession to later developments and reforms.

The Health of the Nation

The seeds of a national health service were sown in the early years of the century long before the debate proper began in the early 1940s. Allsop (1995), includes in her discussion of health policy and the NHS an extract from a paper written in 1901. It expresses considerable alarm that throughout the population the majority were physically unfit to fight in the armed services. In Manchester only one in three “men willing to bear arms” had achieved even the

moderate standards of muscular power and chest measurement required by the army. As for the rest, the two in three, they were “virtually invalids” (p.285). If the State did not begin to work to improve and maintain the health of its fighting population then the survival of the nation as a whole was threatened. Not only was it necessary for the State to build a viable fighting, and in later years working, force, but also to protect its future population by improving the health of women and children. The outbreak of the Second World War, when health care had to be organised on a national scale, gave new impetus to the determination of government to tackle the nation’s health needs (cf. Abel-Smith, 1979, chapter 1).

The principle of equality was basic. It arose not so much from any strongly held ethical conviction but rather from the pragmatic realisation that if the service was to deal with the nations’ health problems, it would need to address the widespread inequalities in health care provision that had arisen under the previous chaotic and fragmented arrangements. *The legacy of the past had resulted in far better provision in the South and towns than in the North and country* (Allsop, 1995, p.66).

Alongside equality, two other principles, namely, *comprehensiveness and universality* were fundamental to the new health care system. These had been identified by Beveridge as key elements in his 1941 paper ‘Heads of a Scheme’; they re-appeared in his final Report of 1942 (Timmins, 1996, p.20; Allsop, 1995, pp.294-

5; Eckstein, 1958), and then formed an important part of the 1944 White Paper *A National Health Service* (Allsop, 1995, pp.289-91).

Looking at the principles underpinning the NHS, one ethicist has observed that they have gained prominence with the passing years as the mythology of the NHS has developed and “vague sentiment” has softened the harsher reality behind the political and professional jockeying involved in the making of the NHS. (Seedhouse, 1994, p.14, 15). It was pragmatism rather than ethical principles that dictated the creation of the NHS. As Beveridge himself made clear, a healthy population made good economic sense: “disease and accidents must be paid for... in lessened power of production and in idleness” (Cmnd 6404, 1942, quoted by Allsop, 1995, p.294). The same pragmatism determined the shape of the original structure. The government saw the need for a system that could provide equal, universal, and comprehensive health care.

The National Health Insurance Act of 1946 went into effect in 1948 allowing everyone to obtain free medical attention from any doctor participating in the national health service (Eckstein, 1958). Thus, for the new health care system to provide the envisaged level of cover it required the support of the medical profession. What values informed that profession’s response?

The Medical Ethos and the NHS

In company with probably all other large organisations the NHS has many faces and performs many functions. It is a monolithic

structure, a vast bureaucratic organisation designed, according to the relevant Acts of Parliament (1946, 1947) to secure improvements in the prevention, diagnosis, and treatment of disease. Prior to its arrival health care provision within the UK comprised an assortment of hospitals funded, often inadequately, from a range of sources, with general practitioner services available only to the wage earning population and paid for out of flat-rate contributions from a variety of associations such as trade unions (Kelly & Glover, 1996; Levitt *et al*, 1995; Klein, 1995). Replacing this complex mix, the new structure could not but be huge and somewhat unwieldy. However, the NHS must also be recognised as an assortment of discreet and distinct communities, each with their own culture and “language”, apparently bound together by a common goal but often, in fact, in conflict with each other (Fox, 1993, p.59). This clash of communities was apparent virtually from the very outset as powerful interest groups, and particularly “a profoundly suspicious body of doctors”, sought to protect their interests within the developing service (Timmins, 1996, p.112).

Thus, although there was widespread agreement that some kind of national health service was inevitable, the final product only emerged after many wrangles and heated debates between, and within, the main parties involved. In some cases the result of these battles was a long-term breakdown in relationships between erstwhile colleagues as has been the case with the Royal Colleges and the

BMA. During the course of the debate, the presidents of the Royal College's were termed traitors and "quislings" by their BMA colleagues and the Minister of Health, Aneurin Bevan, condemned as "an evil" a right GPs were fighting to preserve, namely, the buying and selling of GP Practices. Thus, the end result of all the battles was not so much a happy consensus but a rather bitter compromise (Klein, 1995, pp.2-6; Timmins, 1996, pp.119,125; cf. Webster, 1988; Pater, 1981; Honigsbaum, 1989).

The Medical Profession's Agenda

Lee-Potter in his overview of the early years of the NHS describes from the medical profession's viewpoint the lengthy and detailed discussions that took place before the 1945 general election between the BMA, representing mainly the interest of general practitioners, and the coalition government. The aim of the discussions was to try and find agreement on the best way to achieve a national health service provision. However, once the Labour Party had gained its overwhelming victory in June of 1945, discussion and negotiation ended. Mr Bevan, the newly appointed Minister of Health, was now a man with a mission who saw the National Health Service as his epitaph. He would brook no opposition no matter from whence it came and thus in March 1946 the relevant Bill was introduced, passing into law in November of that year. At this point, "the BMA exploded" and "all-out war" developed between it and the government. The battle continued to rage right up until the NHS was

actually introduced (Klein, 1995, chap.1; Timmins, 1996, p.119; Lee Potter, 1997, p.27). The issue that nearly sank the whole scheme before it got off the ground revolved around remuneration for GPs, although, as is so often the case, there were a number of other complicating factors intertwined about this central problem. Nevertheless, the question of pay was the focus of the GPs, and hence BMA's, opposition.

The GPs Place in the Medical Profession

In order to better understand the reaction of GPs to these proposals this section offers a brief outline of the development of the general practitioner in the medical hierarchy. For this material, I have drawn on standard histories of general practice (cf. Digby, 1999; Loudon, 1986; Honigsbaum, 1979).

In contrast to their physician colleagues who were traditionally members of the upper class, the roots of general practice were very much in the lower stratum of acceptable society. It "carried the stigma of trade" having arisen from grocers who had evolved into apothecaries, "wretch[es] vending poisons" (Loudon, 1986, p.173; Porter, 1997 p.194). The training was a limited apprenticeship that qualified those who completed it only in the dispensing of drugs. This reinforced their lowly position in the eyes of professional doctors for "the extent to which a doctor freed himself from dispensing became the hallmark of professional status" (Honingsbaum, 1979 p.2; Loudon, 1986, p.22ff). Not only did the

physicians write their prescriptions in Latin, the mark of the classically educated gentleman, but once written they passed it down for the apothecaries to dispense. This was so important to physicians that even when the Apothecaries Bill of 1815 sought to enhance the status of the lowly band, the College of Physicians insisted on maintaining their right “to compel the ‘apothecary’ to compound and dispense the prescriptions of a physician, whether he wished to or not” (Loudon, 1986, pp.20,160).

The medical elite’s position on the upper rungs of the developing professional ladder was defended at all costs. Thus, the “degraded position of the general practitioner” was due to the self-interested actions of the Colleges of Physicians and Surgeons “whose impenetrable opposition was based on naked self interest. Neither the medical care of the population as a whole, nor the position of the mass of general practitioners concerned the Colleges when they considered the supposed threat to their autonomy” (Loudon, 1986, p.188).

Physicians, and later surgeons, were also in a position to restrict their practice to those they liked to consider their social peers, the upper classes, leaving the mass of the population to the care of the apothecaries, by now developing into something resembling the modern GP. In due course, to meet the growing demand that their care should include surgical procedures it became necessary for the apothecary to acquire skills in this developing science. But even the

double qualification of apothecary-surgeon did little to enhance their prestige in the elite medical circle. Indeed, developments in medical science overtook the embryo “general practitioner” (entitled since 1858 to be named as such on the Medical Register). More and more health care came to be provided in hospitals presided over by physicians and surgeons as specialists. They now found it to their benefit to offer treatment in those hospitals to the common masses, the general practitioners traditional patient population (Lawrence, 1986, p.15). Thus, began what has been described as “a terrible gulf between hospital doctor and community doctor” (quoted by Honingsbaum, 1979, p.2).

At every turn the GPs saw themselves marginalised by the elite medical practitioners. Even the GMC, set up as part of the 1858 Medical Act, was perceived to be serving the interests of the elite over those of GPs. “Although the Presidents of the Council did not think that GPs’ interests were neglected, representatives of the BMA disagreed” (Digby, 1999, pp.39, 49).

Although, for periods up to the early years of the last century GPs were able to establish a foothold in the hospital sector, it was never more than a concession to meet the needs of a particular set of circumstances. For example, during the 1920s when the voluntary hospital sector was in deep financial crisis, consultants had found it expedient to allow GPs to share some hospital facilities. Once the crisis was passed, however, their attitude reverted to the more usual

hostility. Surgeons “were outraged at the inroads GPs had made on their speciality” and “made a scathing attack on GPs who had strayed” into their territory. Among the consultants only physicians held back because they still had to rely on the GP to bear some of the day to day workload, such as convalescent care, that would otherwise fall on them (Honingsbaum, 1979, p.141). Even this accommodation only lasted a few more years and then physicians too sought to limit the areas in which GPs could be employed. By the 1930s GPs were restricted to working in cottage and so-called home hospitals leaving the treatment of serious conditions to the specialists in the well-equipped hospitals.

In a chapter entitled ‘Consultants Reject GPs’ Honingsbaum (1979, p.301ff), shows how, instead of breaking down the traditional divisions between elements of the profession, the creation of NHS exacerbated them. Although hospitals were critically short of doctors and GPs were available to make up the shortage, consultants were determined to keep them out at every level of hospital practice. Thus, they worked to close the cottage hospitals and even to prevent “conscientious GPs” from visiting any of their patients admitted to hospital. For various reasons, the primary one according to Honingsbaum, being financial, GPs in hospitals were considered a menace. Relations grew more distant and cold with the two branches of the profession now divided by “an antiseptic barrier” (Honingsbaum, 1979, p.302).

This intra-professional hostility forced general practice into a poor second place compared with hospital based medicine.³¹ An editorial in the *Lancet* (1950), expressed the situation of general practice in these words:

The General Practitioner sees himself being elbowed out of hospital, finds himself more isolated from his colleagues in specialist and consulting practice.

The core values of autonomy and self-regulation, arising directly out of the profession's ethos, took on a particular form in the general practitioner arm of the profession. From their somewhat marginalised place GPs came to see their "independent contractor status as a means to defend their professional autonomy" (Lewis, 1997). Thus, that independence became their own core principle to be defended at all costs.

During the run-up to the creation of the NHS it was this principle that GPs fought to protect. They were increasingly wary of efforts to restrict and control them. In their view, at several important points the proposed NHS was designed to do just that, so they opposed the new service.

³¹ In a lecture he gave in January, 2001 Sir Donald Irvine, President of the GMC spoke of this division and described the relationship between consultant and GP in these words: "The greatly expanded body of consultants was riding high, as they were held in awe by patients and, as a group, saw themselves as the elite of medicine.... By contrast general practice only survived because of the State's statutory duty to provide primary medical care, and there were serious misgivings about its quality and safety. It was regarded by specialists as the dustbin of medicine where, as Lord Moran, the President of the Royal College of Physicians of London said, doctors go who have 'fallen off the consultant ladder'. General practitioners

GPs and the NHS

The GPs' first area of concern was the proposal that they should be paid a salary. They feared that if, as the government appeared to want, they became salaried employees they would merely be civil servants under government control. Although Bevan's actual proposal on GP remuneration involved a mixture of salary and capitation fees, the BMA saw this as the slippery slope leading ultimately to full-time salaried status for all GPs employed in the new Health Centres. This fear was by no means groundless inasmuch as Bevan himself had said that he looked forward to establishing a full-time salaried service in due course; furthermore, since 1934 such a system of payment had been official Labour Party policy for all doctors and not just GPs, and the policy had still been part of Labour's plans as late as 1943.

Other aspects of Bevan's plans for GPs were equally distressing to the profession. Particularly so his intention to control the entry of new GPs into areas already well served with GPs, these were usually the prosperous ones, plus his aim of preventing doctors from buying and selling Practices. To help sugar this latter unpalatable pill, Bevan offered the GPs £66 million in compensation for their losses. The other major concern, the so-called "100 per cent issue" that arose from the government's intention to offer 100 per cent health care

had no vocational training – it was not thought necessary. General practice had no

coverage under the NHS thereby ending private practice, had been resolved before this final round of battles. Although the service would be fully comprehensive, covering the whole population, some concessions had been won allowing GPs the right to private practice alongside their NHS work.

A Divided Response

Several elements of the medical profession's negotiations and manoeuvrings are worthy of note in light of that profession's insistence on its over-arching ethical credentials. Looking back on those events, one hospital consultant and former chairman of the BMA presents the situation as follows:

the medical profession's opposition...reflected the absolute nature of a doctor's commitment to an individual patient...Whenever doctors are face to face with sick patients, *duty, ethics and honour* demand that no constraint be placed upon them by an employer, government or anyone else. They must do the best that can be done - even to the extent that it is to the doctor's own detriment...An attack on professional values was detected in [the NHS] Act (Lee-Potter, 1997, pp.28, 29 emphasis added).

Here in unequivocal terms, the medical profession is presented as having taken a united and, more importantly, an ethical stand on the battle line. It was ready to oppose at every turn a scheme that it

impact upon the culture of medicine" (Lancet, 2001, 358, 1808-11.

saw as a threat to its professional integrity and, therefore, to the well-being of patients. Its action was firmly based on the core *principle of medical ethics, standing in defence of patient's best interests even to its own detriment*. This representation is, however, *open to question*.

Opposition to the specific proposals was by no means universal in the profession. Various groups and specialities reacted differently to the proposals depending on whether they saw them as enhancing or threatening their own particular interests. Hence, once the *presidents of the Royal Colleges had gained for consultants the concession of continuing private practice in NHS "pay-beds", and peer controlled merit awards to top-up basic salaries (an arrangement that Bevan summed up in his now famous phrase: "I stuffed their mouths with gold" (Timmins, 1996, p.115), they were generally supportive of the NHS, so much so that they have been termed its midwife*.

On the other hand the BMA, dominated at that time by general practitioners, was, for reasons already discussed above, strongly opposed almost to the last moment. However, even here the opposition was rather specialised. Most GPs were not in a position to give up their time to attend meetings, participate in the debate, and influence the decisions; this was an option for the affluent few, or as Lloyd George had described them on an earlier occasion, "swell doctors", those, in fact, who might be seen as *having most to lose*

from the creation of a comprehensive national health service. However, despite desperate efforts from some quarters for the BMA to continue its opposition, just a few weeks before the NHS formally came into existence, the doctors gave their approval and promised to work to make the service a success.

Notwithstanding these words of support, there is evidence of an underlying antipathy to the NHS by leading voices in the medical profession long after its birth in 1948. Hence Timmins reports that it was not until the mid-1980s that the BMA threw its weight unreservedly behind the Service. Prior to that, the Association's support had been *half-hearted* as evidenced by the fact that even in the late 1970s in a paper submitted to the Royal Commission, it had argued in favour of refinancing and privatising the system (Timmins, 1996, p.412). Klein notes, with some surprise, that by 1958 a Gallup survey of doctors revealed that "two-thirds of the medical profession declared that - given a chance to go back ten years to decide whether or not the NHS should be started - they would support the creation of the service" (Klein, 1995, p.29), this cannot be given much weight in light of the fact that the details of the survey are missing and the profession's ambivalence is thoroughly documented.

All in all, the picture that emerges is of a profession deeply concerned with matters relating to its own well-being. I have already mentioned the fight Bevan had to persuade GPs to give up what he saw as the "evil" practice of buying and selling patients; Enoch

Powell, when Minister of Health in the early 60s commented that all doctors ever wanted to talk about was money; Ken Clarke, during his encounters with the medical profession castigated them for “nervously feeling for their wallets” every time they heard the word reform. Even the profession itself admitted that its objections to the creation of the NHS “could be attributed” to concerns over pay; Klein reports that many of the civil servants who had had to deal with the medical profession in the run-up to the establishment of the NHS were left feeling shell-shocked by the encounters. Such was the impact of facing doctors in defence of their “rights” that, even decades later, civil-servants were reluctant to go through a similar experience of doctors’ representatives pounding the table with their fists and shouting in unison (Timmins, 1996, pp.467-8; Klein, 1995, pp.38, 49).

Nevertheless, it is only right to observe that, while the medical profession itself appears as selfish as almost all other professions, many individual doctors became practitioners for noble reasons, genuinely desirous of helping their fellow humans without thought of personal gain. Even prior to the NHS when fees were a major, sometimes sole, source of income for doctors, GPs practising in the poorest industrialised areas, themselves by no means well-off, were still known to waive the fees of their even poorer patients (Timmins, 1996, pp.107-8; Lee-Potter, 1997, p.23; see also Lantos, 1997,

pp.19,20). One GP recalls “Some we just didn’t bill because we knew they couldn’t pay”.

Notwithstanding such individual altruism, however, payment for service was the only guarantee of receiving medical care; for many it was simply beyond their means and they went without. There was a vast unmet need for health care that only the arrival of the NHS showed up. (Timmins, 1996, p.131). Against this background, the opposition of the medical profession seems difficult to understand in terms of principalist ethics, and particularly when it is remembered that the structure the BMA opposed was, in fact, remarkably similar to one the Association had itself outlined, and its membership accepted in 1942. The opposition was arising not from clearly defined interests and objectives based on “duty, ethics, and honour”, but from the complex intra-medical political manoeuvrings, as each section of the profession sought to protect its domain and promote its interests (Klein, 1995, p.22).

Despite the pragmatism underlying the inception and creation of the Service, it is interesting to note that Bevan himself sought to present the NHS to the nation in undeniably “moral” terms: health care provided for all free at the point of delivery on the basis of need, would create a society that was “more wholesome, .. serene, and spiritually healthier” (quoted in Allsop, 1995, p.28). Set against the background of the rather bloody war he was having to wage with the medical profession, who saw the project in rather less glowing terms,

his use of such high-sounding and moral language was well thought out. The message seemed to be: “what decent person, let alone a health care profession, could oppose such an honourable undertaking?” With the “enemy” occupying this moral high ground the argument was difficult for the medical profession to refute. Eventually they were pacified by the concessions and gave their support.

Controlling the NHS 1948-1969

Despite all the early opposition, the NHS has undoubtedly become one of Britain’s great institutions, and one that everyone with an interest in health care, from professional to politician, must be seen to support. The public posturing has always been to pay lip-service to the NHS. Even Margaret Thatcher, once described as an “Iron Lady”, was forced to change her position and publicly pledge her allegiance to this service in the now famous, albeit somewhat inaccurately reported, phrase “the NHS is safe in our hands”. Webster (1994), notes her actual words as “the National Health Service is safe with us” (p.147). But whatever their level of publicly voiced support, all governments saw the service as costly and in need of control. However, control of the NHS was something the medical profession saw as its prerogative.

Reform of the NHS in one form or another has usually been high on the agenda of any and all governments, no matter their particular political hue, with the focus often on the need to improve the management of the system. Once the new service had begun to operate, Bevan quickly realised the folly of Beveridge's belief that the pool of sickness and disease would shrink as the nation's health needs were addressed. The idea that the population would grow healthier, and that as a consequence the cost of the NHS would diminish, was soon shown to be naive. Before 1948 was over Bevan was having to revise upwards the projected costs for 1948/49 from £176 million to £225 million. At that time the Minister of Health made direct reference to the need to obtain "full value for money". However, he noted that achieving value for money would depend on the successful administration of the Service including, as he specifically mentioned, eradicating abuse by professionals as well as the public (Klein, 1995, p.30).

Among the compromises necessary in order to bring the NHS into existence was that of its overall structure. Although originally the intention had been for a fully integrated service provided locally under one overall administrative unit, this idea did not meet with the approval of the BMA. Its response was outrage. GPs were used to operating as independent businesses, along the lines of the small

shopkeeper, while the majority of hospitals, including the twenty English teaching hospitals, were owned and run by voluntary bodies. The hospitals operated by local authorities were viewed by professional and patient alike as little more than dumping grounds, having often arisen alongside workhouses and, therefore, carrying the stigma attached to those dreaded institutions. Against this background, the idea of bringing the whole service under the control of local government, making doctors in particular “mere” civil servants, was anathema. In discussing the options for the development of health services, Sir Arthur McNalty, then Chief Medical Officer, had, in his paper of September 1939, recognised that both the nationalisation of hospitals and the development of local authority services would be bitterly opposed by the majority of the medical profession. However, he suggested that of the two unwelcome options, doctors would prefer national to local authority control.

The result of the final compromise was not a unified but a tripartite structure formulated along existing lines. Local authorities were given responsibility for environmental and community health services such as child welfare clinics, midwives, health education and the like; GPs, dentists, opticians, and pharmacists continued to operate as independent practitioners administered, but not managed, by executive councils; hospitals services were now administered by completely new bodies, regional boards and hospital management

committees, with teaching hospitals, the elite of the system, given special status and being organised by boards of governors directly linked to, and financed straight from, the Ministry of Health. Thus, the exalted position of the hospital doctor and particularly the consultant was not only preserved but enhanced (Ham, 1992, pp.15-17; Levitt *et al*, 1995, pp.5-7).

Although the compromise structure covered up the problem of controlling the NHS, there was the clear recognition by the political masters, as evidenced by Bevan's own comments in December 1948, that the service needed to move further down the road from simply being administered to being actively managed with some scrutiny of, and hence a degree of control over, health care professionals. It was not a suggestion likely to be met with the co-operation of the doctors, particularly hospital consultants. Despite their opposition, the issue was to re-emerge time and again over the next decades reaching its climax in the events of the 1980s. In the meantime, far from submitting to what they saw as "outside" control the medical profession effectively hijacked the decision-making machinery. Allsop lists professional autonomy among the founding principles of the NHS. Whether or not this was an overtly stated original principle it was in the end, "central to the structure and decision making in the NHS" (Allsop, 1995, pp.29,30). On the back of this principle, doctors were free to define issues as "medical" and thereby place their hands on all the significant levers of control.

Clearly, the institutionalised medical voice within NHS authority provided doctors with an opportunity to medicalise management: to define issues in terms which would ensure that they would represent legitimate, expert authorities. (Klein, 1995, pp.51,52).

The idea that non-medical personnel should have the major decision-making voice within the health service was abhorrent to the medical profession; decision-making lay outside the management, or rather administrative team. Consultants claimed the right to total freedom in defining needs within their specialism, committing capital and revenue expenditure without any significant outside scrutiny. This freedom extended well beyond the care of individual patients and into the realms of resource allocation and political decision-making to the extent that the individual consultant's clinical freedom substantially subverted the priorities determined by the deliberations of the body constituted to make those decisions, namely, the health authority (Allsop, 1995, pp.11,312-3). The doctors saw the managers, or more accurately administrators, role as supporting and assisting the medical profession in the carrying out its vital and life-saving duties (Harrison, 1992, pp.30-55). Any other approach would undermine clinical autonomy and could not be tolerated.

Despite the opposition of the medical profession to outside interference, all governments continued to seek ways of more effectively managing the system. A plethora of reports were

commissioned from 1953 onwards. The first of such, the Guillebaud Report, was set up to look at the workings of the NHS during its first seven years and in particular to enquire into the costs of running the NHS. The Treasury was getting rather concerned at the rising costs to the Exchequer of maintaining the service. In any event Guillebaud advised more rather than less spending, including a £30m capital expenditure programme, and confirmed what Bevan had already recognised, namely, that far from being self-limiting the cost of the NHS would continue to rise (Timmins, 1996, p.206).

In assessing the service, the Guillebaud committee also looked at the tripartite structure of the NHS, but whilst recognising the deficiencies in the system the majority opinion thought organisational change impractical at that time. However one member, Sir John Maude, a civil servant involved in the formation of the NHS, directly attacked the tripartite arrangement with its administrative divorce of general and hospital medicine and the consequent overlaps, gaps, and confusion this caused. Furthermore, he saw the potential for general practice, as well as preventive and social medicine, to slip further into the background as hospital medicine took the dominant position in the service (Allsop, 1995, p.41).

Although several reports following Guillebaud pointed out the problems inherent in the fragmented organisation of the NHS, it was to be twenty years before consideration was given to a major restructuring. In the meantime the concerns expressed by Maude

were shown to be well-founded. Hospital services, and particularly the acute sector, continued to dominate provision of health care. Within this context, hospital consultants remained free to provide treatment and care for patients according to their independent professional judgement, unaccountable to the NHS authorities for their clinical and, by extension, spending decisions. The result was that the pattern of provision was shaped not by the centre but by the periphery and, more significantly, by the strongest elements of the periphery, those consultants able to exert the greatest influence. These inevitably represented the most prestigious specialisms in the acute sector such as surgery. Long-stay, chronic services were soon classified as the “Cinderellas “ of the NHS. Neither the doctors involved nor their patients were in a position to make themselves heard when it came to clamouring for resources. They were simply drowned out by the voices of their more powerful colleagues. As one Minister of Health observed: “doctors can be remarkably selective in choosing the ills they regard worthy of treatment....No one can see better than doctors the.... shortcomings of the service. I am not aware that there has been steady, powerful, informed medical pressure to remedy [those] shortcomings” (Klein, 1995, p.73). From the great heights of the favoured acute hospital sector the activities of community and particularly public health practitioners were viewed with some disdain. Many years later, and despite numerous

efforts to improve their standing, Griffiths termed this sector the health service's "poor relation".

Furthermore, initiatives to encourage doctors to take a more direct interest in the cost implications of their clinical decisions (for example, *Priorities and 'Cogwheel'*, see Godber, 1967), did not meet with great success. That is not to say, however, that doctors were unaware of the resource issues. Very soon after the inception of the NHS they realised that they were now part of a system for rationing scarce resources (Klein, 1995, p.36).

The problems of lack of integration, inefficient use of resources, and poor provision for certain patient groups were recognised as part and parcel of the same weakness: the system of administrative control of the NHS, in other words, the tripartite structure. By the late 1960s, hospital services in England and Wales were organised under 15 regional hospital boards, 36 boards of governors, 336 hospital management committees, 134 executive councils administered general practitioners, and 175 local health authorities were running community services. The time had come to abandon the caution of Guillebaud and attempt a re-structuring.

In its report of 1962, the Porritt Committee had recommended the formation of area boards under which the other elements would be unified. This recommendation, coming as it did from the medical profession itself, indicated the extent of the disillusionment with the tripartite system for it had originally only come into being in response

to pressure from that same profession (Levitt *et al*, 1995, pp.10-11; Allsop, 1995, pp.48, 42; Klein, 1995, p.82). Six years later the Labour government, under Kenneth Robinson as Minister of Health, published its first Green Paper asking for responses to the proposal that health services should be unified under forty or fifty area health boards. It was, furthermore, recognised that the ideal arrangement would be for health services to be transferred to local government. However, knowing the opposition of the medical profession to local authority control, the political decision was made not to even include this item on the agenda for discussion.

1969-1979

Over the next five years the proposed reorganisation slowly took shape. The process taking place against a rather confused political background, inasmuch as it began under a Labour government with the first Green Paper, followed in 1970 by the second Green Paper, produced under Richard Crossman as Secretary of State for the Department of Health and Social Security. It then moved under the control of a key Conservative secretary of state, Sir Keith Joseph, who published his proposals in 1971 and steered through the White Paper and the relevant legislation. Finally, in 1974 the reorganisation itself took place. But in the meantime, the Labour party had been returned to power and so the new Secretary of State found herself implementing a reorganisation devised by her Conservative predecessor.

Although there had been widespread agreement on the need for reform and, apparently, on the general shape of that reform, in the end the Conservatives had rejected many of the previous administration's proposals. Consequently, although the reorganisation went ahead as planned, by July 1975, Barbara Castle set out her own proposals for further, relatively minor, changes. However, the reorganisation of 1974 stood as a milestone in NHS history. In place of the 700 different authorities involved in running the NHS, there were 15 regional health authorities, 90 area health authorities usually covering the same geographical area as the local authorities, and department district management teams. The great teaching hospitals lost their special status, despite loud protests from the Royal Colleges, and Community Health Councils were established with the aim of giving the consumer some influence over the provision and planning of services.

Both these developments were indicative of a change in attitude that was gaining pace even then. Nevertheless, the dominant voice was still that of the medical profession and although the protest over teaching hospitals was ignored, mainly because the influence of the elite consultant group linked to these hospitals had been watered down by the expansion in the number of consultants now based in the district general hospitals, the views of the profession in general were heard and responded to. Hence, although the central aim of the 1974 reorganisation was unification of the NHS, because this did not

accord with the wishes of sections of the medical profession, it didn't actually happen. General practitioners remained as independent businesses under essentially independent family practitioner committees. Furthermore, as well as managing their own professions', a representative from the main professions sat on the *management team of each of the three tiers of administration: district, area and region.*

The aim was to create consensus management; at every level, every interest was built into the formal structure of the organisation thus the enormous power of the medical profession would be diluted and a common purpose would guide the decision-making. However, in practice this was an illusion. Although doctors might be prepared to sit on these bodies, ostensibly as part of a team, the profession as a whole simply refused to be managed. The great reorganisation had not altered one fundamental aspect of the NHS; it continued to be "a giant state organisation controlled simultaneously by Whitehall and thirty thousand doctors" (Strong & Robinson, 1990, pp.18- 20).

Alongside the reorganisation another battle was in progress within the NHS. It was actually being fought on two different, albeit closely related issues: the abolition of NHS pay beds, and consultants contracts. The pay beds issue had come to the fore as a Labour manifesto pledge; the dispute over contracts had been inherited from Keith Joseph's time. Barbara Castle recalls that her negotiations with consultants to separate private practice from the NHS by phasing out

pay beds were “complicated by the fact that the consultants were pressing for a new contract to cover their services with the NHS”. She then notes that “they were in an ugly mood” and “were very near to downing tools” (Castle, 1993, p.481).

The medical profession was, indeed, bristling with anger. The resulting confrontation was “the most bitter political struggle since the inception of the NHS (Klein, 1995, pp.106,110). On both sides the battle was presented as a moral crusade. The politicians, for whom pay beds had not been an issue over many years, suddenly re-discovered it as a fundamental principle. Social justice demanded that the traders be driven out of the temple of the NHS. The consultants were equally determined to present their position as a defence of their independence and thus the only safeguard of patients best interests. In reality, both groups were motivated as much by self-interest as anything more honourable. Unrest in the NHS unions over pay beds, comprising less than one percent of the total number of NHS beds, led the politicians to calculate that the policy of doing nothing would on this occasion be more politically expensive than actually addressing the problem. They decided to act (Timmins, 1996, pp.331-335; Klein, 1995, pp.107-8). The consultants also made a political calculation and decided that defence of their independence, itself a rather fragile symbol inasmuch as most were well and truly dependent on the NHS for the major part of their income, was, nevertheless, so vital that they would have to take

industrial action. Very soon junior doctors and GPs were making their own threatening noises. In December 1974 the medical profession flexed and then used its industrial muscle.

In her account of this fraught time, Barbara Castle recalls that one aspect she found most interesting about the battle with the consultants was that they had no desire to get rid of the NHS, it was their bread and butter, but it was simply that on top of the butter “they wanted a liberal serving of private practice jam”. The independence for which they were fighting, as she saw it, was freedom to give priority to their private patients while allowing their NHS patients to wait for treatment (Castle, 1993, p.483). The consultants’ chief negotiator, Anthony Grabham, made clear that although his instincts lay with the NHS, his desire to protect the interests of doctors was stronger. He was, therefore, determined to safeguard private practice.

The long, acrimonious, confrontation finally came to an end. Behind the back of the Secretary of State, with whom the consultants refused to continue negotiating having, in the words of Lord Goodman chief mediator in the dispute, “developed a positively insensate hatred”, the Prime Minister, Harold Wilson, was persuaded to meet the doctors. “Punch-drunk with economic problems... Harold...was ready to sue for peace with any vested interest” (*ibid.* p.484). After further to-ings and fro-ings an exhausted compromise was reached. The immediate result was the formal recognition by

the Government that doctors should continue private practice alongside their NHS work with the majority of pay beds only phased out gradually.

If this immediate outcome was a victory for the consultants the longer term legacy was, in the opinion of many observers as well as those closely involved in the dispute, far less positive for the profession as a whole. Its moral authority had taken a severe knock. The oft repeated claim that doctors put patients interests above everything else, even to their own detriment, was shown to be false. Doctors had used naked coercion, had been prepared to harm “their” patients, in order to pursue their own objectives. Although many individual doctors had been horrified at the actions of their profession, and following the events just described membership of the BMA dropped sharply, the fact remained that the medical profession had pursued its claim as ruthlessly as any other group. Thus, while Klein reassuringly claims that the consensus survived this experience, battered but essentially intact, perhaps Timmins’s suggestion that the seed for the end of consensus had been sown, would appear to be more accurate (Klein, 1995, p.112; Timmins, 1996, p.340). A new political administration was waiting in the wings, one that dismissed conciliation and compromise as, in the words of its leader Margaret Thatcher, “government by ‘bendy toys’”. Among these politicians, the determination and the power

demonstrated by the medical profession's trade union raised serious questions.

One of the aims of the 1974 reorganisation had been the more effective management of the service. And yet, as already noted, doctors remained stubbornly resistant to any external management. In practice all formal organisational arrangements had been designed specifically to leave doctors free from day to day management. So although they were involved in the decision-making process as members of the team, the profession itself was rarely the subject of the decisions the team made (Harrison *et al*, 1992, pp.23,24; Harrison, 1988). One regional director described NHS management at that time as "just a talk-shop, a devilish waste of money. Nobody took on the clinicians" (Strong & Robinson, 1990, p.66). However, as the seventies drew to a close the idea that the most powerful group within the NHS, namely, clinicians, should remain outside effective management control was increasingly perceived to be detrimental to the well-being of the service as a whole. In the new political climate created by the Thatcher administration the notion was about to be vigorously challenged.

1979-1993

During the 1980s the Government introduced a series of radical changes in the way public services as a whole were managed. The term "new public management" has been applied to these changes

(Hood, 1991). The main characteristics of this type of public management were:

- hands-on professional management;
- explicit standards and measures of performance;
- output controls;
- decentralisation;
- competition and mixed provision;
- private sector based models of management;
- emphasis on economy in resources.

(Talbot, 1994, pp.1,2).

After setting out these criteria, Talbot goes on to quote the Head of the Home Civil Service Sir Robin Butler's re-assurance, that alongside these changes there is also an "agenda for continuity" with the need to strengthen the traditional ethical values of fairness, probity and equity in public service, "the essential values and ethics that make our system work". The language used in relation to the changes that were about to take place within the NHS, even in the titles of many of the government papers, reveals a similar effort to maintain the myth of guiding ethics and building on underlying moral values.

Inheriting as it did a Royal Commission report on the NHS the new Conservative government carried out a not insignificant but, in the light of what was to come, relatively minor reorganisation in 1982. This removed the middle tier of the NHS structure, namely,

the area health authorities. During this period, doctors won a further round in their ongoing and protracted negotiations with government. The issue of consultants' contracts was finally settled very much in the doctors' favour with increased opportunities to top up their NHS salaries through private practice. There was also an interesting little concession granted to GPs: they were now allowed to employ their wives as secretaries and assistants. All previous ministers had refused this arrangement considering it too open to abuse. Such developments must have given the medical profession at least, grounds for cautious optimism as it contemplated the future. If such was the case the optimism soon disappeared and the profession found itself embroiled in the fiercest battle it had ever had to wage.

Although Kelly and Glover reject the notion that the changes that occurred in the NHS during the 1980s were revolutionary in nature and Webster documents a long-standing animosity toward the NHS felt by virtually all Conservative administrations (Webster, 1997, p.54ff, Kelly & Glover, 1996, p.29), many other analysts have described much of what happened during those years in terms of a revolution. Harrison and Wood (1998) discuss the periods of change I have described, as a movement away from what they term the blueprint approach with its policy/action dichotomy to "the bright idea" approach that begins with a sketchy outline with specific action developed on the hoof once the bright idea has become policy. The creation of the NHS falls firmly into the first category whereas,

as the authors make clear, the Griffiths and related reforms are most decidedly in the second. The proposals and the policies arising from them have been called “the assault on the old ways”, “a huge and perhaps irrevocable change”, “radical”, and “a major new direction” (Strong & Robinson, 1990, pp.5,27; Levitt *et al*, 1995, pp.24, 31), and Harrison *et al*, (1992) identify the creation of general manager posts and the emphasis on sanctions and incentives as performance motivators as “crucial potential breaks with the past”. In setting out the details of the unfolding drama both Klein and Timmins cannot but help convey the sense of something revolutionary happening within the Welfare System as a whole and the NHS in particular (Klein, 1995, p.176ff; Timmins, 1996, p.453ff).

The first hint of the practical application of the new managerialism to the NHS was spelled out in a series of White Papers bearing titles that seemed designed to chime in with the core ethical principle of health care providers, namely that care of patients is the prime consideration. Thus, *Patients First* (DHSS, 1979), although written before the period of major reform, advocated a simplification and streamlining of management by the removal of the Area tier. Following the Griffiths Report (1983), “which marked the beginning of the NHS’s managerial revolution” (Klein, 1995, p.131), the Government sent out Circular HC (84) 13 (DHSS 1984), informing Health Authorities of the Secretary of State’s intention to appoint General Managers. The aim was more effective decision-

making through “tighter control and less ambiguity of purpose” (Levitt *et al*, 1995, p.24). Then came *Working for Patients* (DoH 1989), which took the Griffiths reforms a stage further with the creation of the internal market. The purchaser and provider roles were to be separated with health care providers, both hospitals and community services, becoming autonomous trusts competing with each other to sell their services to the health authority purchasers; general practitioners, above a certain size, would also be given control of their own budget out of which they would purchase services for their patients. Other reforms set out in this paper involved strengthening lines of accountability: giving managers greater control over consultants, with consultants’ contracts negotiated at local level between Trust and consultant, and managers having more say in merit awards paid to consultants; furthermore, medical audit was to be extended throughout the NHS.

Despite the revolutionary nature of these changes, by 1993, further efforts to simplify the higher levels of NHS management structure were underway. *Managing the New NHS* (1993), outlined further reforms: merging DHAs and FHSAs, abolishing RHAs in England, and streamlining NHSME. All these changes met a powerful response from the medical profession as will be discussed in the next chapter.

Summary

This chapter has explored the attitude and approach of the leaders of the medical profession to the creation and management of the NHS. The intention was to uncover the interests and concerns that fuelled the profession's responses. Setting the actions of various factions within medicine alongside those of the related political intrigues has been illuminating.

The political decisions were the product of the tensions between that which was ideologically desirable, economically possible, and politically expedient. Medicine claimed, and claims still, a different approach to its decision-making: "medicine is a profession which...marches to a different drummer than most other occupations" bound by the demands of duty, ethics, and honour (Lee-Potter, 1997, pp.28,29). But this chapter has shown that this is another part of the profession's mythology that helps to maintain its prestige and status in the eyes of the general public. It is not grounded in the reality of their actual record particularly when that record deals with threats, real or imagined, to the profession's position and power. Thus, the profession's response was true to its ethos with each section working to protect their own interests and the profession as a whole manoeuvring to establish effective control over whatever structures were put in place to manage the Service.

It might be argued that the profession's response to these events was untypical and exceptional because it genuinely feared, in the

first instance, that the NHS was an institution that was going to undermine health care in the UK and, in the second, that government was about to dismantle the Service it had over the intervening decades come to love. This argument deserves further examination, so this part of the study will end by exploring in closer detail day to day values typically linked to management to see how comfortably they sit under the umbrella of the medical ethos.

Chapter 4

Values in Conflict?

Be a physician, Faustus, heap up gold,
And be eterniz'd for some wondrous cure
Marlowe, Doctor Faustus, Act 1, Sc. i, line 14

Doctors have always got this sense of their
own importance and self importance and how
wonderful they are and now they control the
money as well.

A reluctant fundholder, 1996

This chapter will compare and contrast some of the key values in medicine and health care management. It will then move on to look at areas of perceived conflict between medicine and management and at the impact of such conflict on those who took on the dual responsibilities of management and practitioner.

Medicine and Business

“Medicine is a noble profession but a damn bad business”.

Perhaps in that phrase (quoted by Lee-Potter, 1997, title page), Sir Humphrey Rolleston draws attention to what many will see as the real difference between medicine and business management.

While within, for example, academic circles, it may be recognised that management *per se* is not synonymous with business, traditionally, management and business are closely allied as indicated by the fact that management ethics is generally thought of as a business subject (Snell, 1993, p.xi). Management is linked to business and business is about money and specifically the making of profit. Medicine should not be seen as concerned with interests of

business. Amongst medical staff, Fisher and Best (1995), found a “very negative attitude” toward the business management role (p.48). Digby noted that “the economic history of medicine is a strangely neglected field, relatively little is known as yet about ... the business side of medical practice”, and suggested “one reason for this may have been the emphasis given by an older tradition of medical historiography to a history of great men, clinical advances, and notable institutions” (Digby, 1994, p.1). Thus, part of the mythology of medicine is that it stands above such base interests as money. Yet the NHS Reforms appeared to force onto the Service and its dominant profession, medicine, this interlinked trio of management, business, and money.

Around the core objective of running a successful business Drucker (1988, p.27f), has identified seven functions of management. They centre on having clear objectives, devising practices and standards for meeting those objectives, and making all involved accountable for their practice in relation to those objectives. These functions are based on standards suited to running commercial enterprises such as the supermarket and the factory. In this context, management was the intimate and obvious bedfellow of business and there was a strong resistance, both within the profession and among the wider population, to that type of management operating so intimately within the NHS and especially the practice of medicine. This chapter begins by analysing the validity of this concern.

From empathy to economics

For centuries the family was the first line of defence against illness; care of the sick and much of the healing, the domain of women. “The art of healing was linked to the tasks and the spirit of motherhood; it combined wisdom and nurturance, tenderness and skill”. “The family was natural source of care for the sick, and within the family such care fell to women”. “Women practised medicine as a domestic art” (Ehrenreich & English, 1979 p.30; Nelson & Nelson, 1995, p.6; Witz, 1992, p.77). In time, as communities grew and became more structured such ministrations were supplemented by the help of a person particularly skilled in dealing with sickness, for example the wise-woman or, more significantly, the shaman (Porter, 1997, pp.30-33) but also noble women and wives of clergy who have been described as ‘the unofficial doctors of the village’ (Witz, 1992, p.77).

Thus, “with settlement and literacy conditions were ripe for the development of medicine as a belief-system and an occupation” (Porter, 1997, p.33). An occupation is pursued, certainly in part, for some financial return, as Plato observed of the charges made by physicians of his time: “Unless pay is added to it there would be no benefit to the craftsman, and consequently he would be unwilling to go to the trouble of taking care of the troubles of others” (Plato). In due course medical practitioners sought, and even fought to be more than an a mere occupation. They wanted to become a profession.

This whole movement took medicine away from a women-centred provision of care within the home to a man-dominated medical profession and made it a business, a commodity to be bought and sold:

The historical antagonist of the female lay healer was the male professional.....A profession is.....defined by its *exclusiveness*, and has been since the professions of medicine and law first took form in medieval Europe....While the female lay healer operated within a network of information-sharing and mutual support, the male professional hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity. His goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession came to represent... *Medicine in the nineteenth century was being drawn into the marketplace, becoming - as were needles, or ribbons, or salt already - a thing to be bought and sold* (Ehrenreich & English, 19979, p 30, emphasis added).

It can be protested that this picture is based on the North American situation where medicine is historically far more commercially oriented. In Britain the development was motivated less by avarice and more by altruism. If this is the case, it is only so up to a point.³⁴ It was the European, and particularly the British,

³⁴ In their study, Ehrenreich and English argue that the means by which American "regular" doctors achieved their exclusive professional status were mainly economic

model of the prestigious medical professional, and specifically the University trained physician, as against the mere surgeon and apothecary, that made a powerful impression on American medical students fortunate enough to be able to spend a few years of their medical studies in Britain and Europe. Thus, it was that the young Benjamin Rush, who in time was to become “the America Hippocrates”, found in Europe “his status as a medical graduate gave him access to the cream of London and Parisian salon society”. Once Rush and his medical student colleagues, had glimpsed, albeit briefly, the heights to which the profession of medicine could aspire they, unsurprisingly, urged their fellow practitioners to adopt the European model (Porter, 1997, p.266; Ehrenreich & English, 1979, pp.37, 38).

Witz (1992, pp.77-79), identifies the general movement toward a more market based provision of medical services as one of the key developments in the demise of the female medical practitioner. Lawrence (1996), in her study of voluntary hospitals and medical teaching in eighteenth century London, observed that :

and, indeed, very different from some of the methods used in Britain and the rest of Europe. There, they contend, the developing medical profession took full advantage of the witch hunts to remove “the great mass of female healers”. “The witch trials established the male physician on a moral and intellectual plane vastly above the female healer. It placed on the side of God and Law, a professional on a par with lawyers and theologians, while it placed her on the side of darkness, evil and magic” (pp.34, 35). This assessment is disputed. Although the ability to cure or heal was taken as the sign of a witch, Porter states that “there is little evidence....that female healers were charged with witchcraft”. He notes, however, that upwards of 50000 victims, mainly women, were tortured and executed during the witch-craze (Porter, 1997, pp.128, 130).

the catch-all operations of supply, demand, and market price .. apply just as well to the "medical market-place". People bought and sold medical goods, from drugs to books and medical services, from a local woman's nursing care, to an elite physician's advice or a practitioner's course of lectures, as cash commodities (p.6).

Noting, furthermore, that throughout the entire period covered by her study, women only appear as patients, the relatives or friends of patients, or marginal servants, she comments:

Public hospital medicine thus contrasted overtly with private domestic medicine, in a way that reinforced the dominant place of male practitioners as those in charge ... of what happened to the sick and injured but also of how that appeared in the *medical literature* (p.28).

Alongside these changes to a public profession Lawrence found a range of coexisting values and motives in the medical practitioners of the eighteenth century (Lawrence 1996, p.36). By donating their medical services to the newly developing charitable institution practitioners gained professional and social status as well as cash benefits (Digby, 1994, p.4). Nevertheless, alongside the self-interest there was also altruism, a care for the patients motivated by genuine concern. Likewise, hospital organisers wanted their institutions run like businesses, accruing immediate and long-term social profits, with efficiency, effectiveness, and accountability; yet these goals were

pursued in the context of ensuring that the poor and needy received care and shelter under their roof.

Freidson, in reporting various studies into the reasons for present day students taking up medicine, found a similar mix of motives and values, some altruistic, some more avaricious. Service orientation was important to a number of those interviewed. Many individuals took up medicine out of a deep concern for the well-being of their fellow humans and an unquestionable desire to help those who suffer. The “opportunity to be helpful to others” and “being of service” were among the values espoused by many aspiring medical students. However, those same studies also noted that public service values were not as widespread among the students as might be popularly imagined, and other values, described as “*more characteristic of the businessman*” were also well represented, including the desire to achieve status and a high financial return (Freidson, 1970, pp.172-178 emphasis added). Thus, the practice of medicine as a profession combines a number of contrasting, even conflicting values.

A Place for Profit?

Although the NHS removes the direct exchange of money between consumer and provider, the notion that health care in the UK is untainted by contact with money or, even worse, profit, is quite erroneous. Many consultants, alongside their NHS work, run a

business, a private practice for profit. Even within the NHS, as I have already noted, private pay beds were a concession granted to consultants in order to gain their support for the Service and one they fought to protect. No part of *Duties of a Doctor*, described by Lee-Potter as the GMC's "ethical bible" (Lee-Potter, 1997, p.29), or BMA codes of conduct, forbids doctors from making money out of selling their skills. Profit itself is not immoral, nor is it professionally unethical, otherwise how could any doctor in any situation practice for profit without the GMC taking action? Yet doctors have traditionally sought to hide this motivation for practice.

Writing of general practice in the mid-1800s Digby (1999), comments:

Business sentiments...were the bottom line for survival in general practice. But the gentlemanly pretensions of the British medical profession meant that those were seldom articulated; elevated medical ideals were seen as respectable aims, but mercenary realities as shameful, even dishonourable objectives (p.95).

The situation is no different today. At the heart of the NHS are GPs, the gate-keepers to the service. Yet GPs operate as private businesses, the "small shopkeepers" of healthcare within the UK (Seedhouse, 1994, p.20; Kelin, 1995, p.202). Good business practices, especially balancing the books and remaining solvent, are important. Thus, far from considering business values as inherently

antagonistic to the NHS values, GPs have fought hard to protect their status as independent small businesses. In their view, patient welfare was tied into protecting this status. GPs' saw their independence as the only way to maintain their clinical freedom and prevent excessive State interference, thereby protecting patients' interests.

Indicative of the importance of sound business practice to GPs, is the content of journals such as *Medeconomics*. In any copy picked at random there will be articles offering very practical business advice on topics such on good management practice. How to control practice costs, where to get the best insurance deals, Internet Banking, and columns devoted to answering questions on personal and Practice finance are all suitable issues to address to its general practitioner readership (a typical example *Medeconomics* vol. 20. no. 11).

One GP interviewed for a medical advice television programme explained the situation of the GP Practice very clearly as follows: "A Practice has to be a business; you have to balance the books. We are small business men and the money we take home is what is left after we have paid the expenses" (Moss, 1998).

An article in *Pulse* (Winchester, 1998), showed that consideration of the financial implications of failure to meet government set targets on immunisation and screening is common among GPs. Alongside discussion of other areas of concern

following an, at that time, recent “screening scare” it reported Richard Winder, deputy national co-ordinator of the screening programme, as saying “he did not expect the scares to threaten GP target pay”. The report continued by pointing out that “the latest data available...showed 90% of GPs were achieving the higher target payment for 80% coverage. “We will be...working hard to avoid any drop in uptake which is currently running at around 85 per cent”.

In similar vein, a Scottish GP commented adversely on the very different financial inducements offered to their English GP colleagues. Scottish GPs were not given payment for ‘flu vaccinations nor did they have the freedom to make a profit on the purchase of the vaccination. In her view, this anomaly should be changed as “this would encourage GPs to ensure that the at risk populations were vaccinated” (*Doctor*, 1999b, p.111).

The Royal College of General Practitioners, in its guidance to GPs on the subject of removing patients from GP lists (RCGP), advises its members that although it would not normally be justifiable, patients who “refuses cervical screening, declines the immunising of the children, and does not comply with therapeutic or other health advice” can be removed from the GP’s list.

Commenting on the fact that some parents have been removed from a doctors list because they refused to vaccinate their children Dr Moss (1998), candidly observed: "I'm sure patients are removed

from doctor's lists in some cases because of financial reasons....In my Practice we have three doctors and for us, if we hit all our targets, [vaccinating 90% of child patients] we can make about 15000 [pounds], if we do it perfectly. That's not to be sneezed at". In other words, the need to balance the books can, on occasion, influence the doctor's relationship with the patient.

This admission contrasts with the explanation offered by a spokesman for the BMA when asked to comment on the RCGP's guidance. He explained that as the doctor-patient relationship is voluntarily entered into on the basis of trust, more akin to a friendship, the refusal to accept medical advice and treatment indicated a breakdown in that trust, a breakdown in the friendship. In such a circumstance, the doctor may feel she or he has no alternative but to remove the patient from their list (Goss, 1998). Here the College's advice to its members was justified to the general public on the familiar principalist ethical grounds, namely, the nature of the doctor-patient relationship. Financial considerations were not mentioned perhaps because, as in the case with the 19th century practitioners of Digby's study (1999, p.95), they might present the wrong image.

Whilst it would be inaccurate to say that financial and business concerns are paramount in the mind of most doctors, it is equally inaccurate to present the practice of medicine, even within the context of the NHS, as above any interest in such matters. Klein

describes the belief that the NHS divorced the practice of medicine from money as “perhaps one of the most important founding myths of the NHS” (Klein, 1995, p.195). And although doctors may assert, as did one of the GPs I interviewed for this research, that they know precisely where to draw the line in order to ensure that patients’ interests are protected at all times, this too is an ideal, or even, one of the most important myths of modern medical practice rather than an everyday reality.

The influence of values other than the values of the formal explicit professional medical ethics, including those more commonly associated with business, may be less obvious in the case of the doctor than the manager, nonetheless the influence is, and always has been there. It rises from the profession’s ethos, its fundamental moral tone, reaches into the heart of modern medical ethics, and the doctor-patient relationship with its values of patients best interests and clinical autonomy.

Core Medical Values

Patients’ Best Interests

“Make the care of your patient your first concern” (GMC, 1995, inside cover). This, according to the GMC, lies at the heart of the trust patients vest in their doctor. The so-called core values of commitment, caring, compassion, competence, integrity, confidentiality, responsibility, advocacy, and even spirit of enquiry

(BMA, 1995, quoted by Allen, 1997a, p.3), can be seen as embedded in this primary statement of duty.

Despite the expectation that the doctor acts as the “perfect agent” (Mooney, 1992, pp. 28, 29, 79, 80), for each patient, that is to say takes no account of interests and values other than those of the patient, in practice the medical practitioner is, to a greater or lesser extent, pressed to consider a number of interests and values other than those of the individual patient. These can include professional or academic interests such as might arise if the doctor is involved in clinical trials or research, business interests especially in cases of fees for service and where some aspect of the service is sponsored by a medical supplies or drugs company, personal political interests and those imposed on the doctor as a representative of the state (Sheaf, 1996, pp.104-5,111). Many of these interests potentially conflict with that which is presented as the doctors “first concern,” namely, patients’ interests.

Patients Best Interests and the Doctor-Pharmaceutical Relationship

There is a “close alliance between doctors and the pharmaceutical industry” (Kelleher *et al*, 1994, p.ix), that has been strengthened and enhanced by each new pharmacological development.

The relationship between the pharmaceutical companies and the medical profession is, unsurprisingly, of special importance to the industry. Sales of medical drugs amount to \$300 billion a year and in

1996, the average profit margins of the ten largest drugs firms was 30% (*The Economist*, supplement, 1998). It is in the interests of the large pharmaceutical firms to influence doctors to use particular products produced by these firms and they have become highly skilled at exerting this influence, often in rather subtle ways. The nature of this relationship is one that, nevertheless, raises concerns in the context of patients' best interests. Particularly so as evidence suggests that it can even lead to the medicalisation of what might otherwise be seen as a "normal" human condition.

For example, the vast increase in demand for fertility treatment is now an industry worth \$2 billion a year. Once a couple is classified as infertile, and that can happen if they have not managed to conceive after just 12 months, they become suitable candidates for expensive fertility treatment. A television report exploring this issue ended with these words: "This baby boom is all about science becoming big-business and business is booming" (Channel 4). Within the UK, fertility treatment is linked to ability to pay and is thus, in many areas, only available "to privileged women" (Lupton, 1994, p.160). The whole issue is one that has raised considerable concern among feminist scholars (cf. Sherwin, 1992).

Hence, whilst the doctors' ethical code is meant, among other things, to assure patients that clinical and not economic objectives guide the doctor's decision, the 'invisible hand' of market-based pressures may be subverting that protection (Evans, 1981, p.337).

Patients' Best Interests and Consumer Demand

Doctors themselves point out that patients can put them under pressure to prescribe a treatment or order a procedure because it is expected by, rather than specifically indicated for, the particular patient. The vagaries of 'consumer demand' are seen, by doctors at least, as putting the clinician under increasing pressure to act, not according to her or his best professional judgement of patient interest, but on the basis of the patient's insistence on receiving a treatment about which the patient has heard. One doctor-directed journal carrying an information poster advertised it as follows: "Are you tired of patients demanding antibiotics when they just aren't appropriate? Use our patient information poster to cut down on your wasted time" (*Pulse*, 1998, p.1; Gabe *et al*, 1994, p.186).

This assessment appears, however, to be very much a matter of perspective, for research indicates that rather than increased consumer demand for drugs the mood over the last couple of decades has shifted more towards a questioning of what is seen by patients to be the doctors' over-enthusiasm for the routine use of prescriptions. There is among patients "a pervasive anti-drug culture", in relation to prescribed medication, linked, according to the authors of the research, to a more conservative moral order that includes self-reliance along with autonomy and personal freedom (Gabe & Bury, 1996 pp.76,90; Calnan & Williams 1996, p.40). Other research suggests that while doctors may interpret patients

needs and expectations in terms of a prescription for antibiotics, what patients themselves often actually want is information and reassurance (Butler *et al*, 1998, pp.637-642).

Patients' Best Interests and the Common Good

It is not difficult to see that the emphasis on what Veatch terms “traditional Hippocratic individualism” (quoted in Mooney, 1992, p.86) sits rather uncomfortably with the more ‘common good’ community-wide approach that must underpin the health care managers’ decision making. Wall sets out rather well what is still widely perceived to be this fundamental difference:

managers are unable to return to the safety of the Hippocratic oath which endorses the supreme right of every single patient to expect that their physician will always act unambiguously in their interest (Wall, 1995 p 1).

Here then seems to be a direct conflict; one that would, at least theoretically, create ethical problems for those undertaking any dual role as practitioner and manager. Once again, however, an analysis of the situation shows the everyday reality as rather less antagonistic. To begin with, any potential conflict arises not between an ethical and an unethical set of values but rather from different sets of ethical positions. The deontological tradition is ostensibly the one from which medicine draws its ethical principles. “Duty” for the doctor is duty to her or his patients, “patients’ best interests” is the over-riding

consideration.³⁵ The manager's guiding principles are derived from a utilitarian ethics, one that emphasises the common good.

In determining which ethical position should dominate decision-making within the NHS it is worth remembering that the service was founded on collectivist, utilitarian principles. Yet, as Mooney observes, even when the BMA in its *Handbook Of Medical Ethics* acknowledges a general duty on the part of the doctor "to advise on [the] equitable allocation and efficient utilisation" of resources, this is subordinated to the "professional duty to the individual who seeks his clinical advice" (Mooney, 1992, p.86). Quoting Jonsen and Hellegers, Mooney asserts that the individualistic "patient's best interest" emphasis is flawed and argues with some vigour for the inclusion of considerations of the "common good" in contemporary medical ethics. The BMA's position appears to be endorsed by the GMC in its guidance on good medical practice. Thus, in its outline of good standards of practice and care the emphasis is on the care of the individual patient, no mention is made of concern for utilisation of resources apart from the one small reference in the body of the text which simply reads "pay due regard to efficacy and the use of resources" (GMC, 1995, p.3).

³⁵ In deciding on the best treatment for the individual patient, however, the doctor uses consequentialist reasoning, asking what treatment will produce the best consequences, the greatest utility, for my patient. Nevertheless the central underpinning moral principle is deontological: duty to the individual patient regardless of consequences beyond the needs of that individual patient (Vang, 1988, p.140).

Despite these clear statements on the overriding moral obligation of the doctor to her or his individual patient, it is interesting to note that Gillon (1988), a leading medical ethicist and editor of one of the definitive works on medical ethics, dismisses as a mere simplistic stereotype, the notion that doctors always put the interests of the individual patient first. Using examples from his own clinical experience, he shows that in practice doctors recognise competing moral claims and take these into account in their decision-making. Accordingly, the assumption that the interests of the individual patient always take precedence over the interests of others is not only “intuitively somewhat implausible” but “when clinical examples are adduced even more impossible”. Thus, he declares: “there need not be and should not be any unbridgeable moral chasm between medical ethics and health care economics” (pp.114-115). In other words, in this essential area, the core value of the doctor’s practice does not conflict with values of the common good underpinning much of the decision-making of the manager because doctors do not recognise it as overriding.

Gillon’s contention appears to contradict the apparently unambiguous statements from both the GMC and the BMA on what constitutes ethical conduct. It is also at variance with a belief held by many doctors. Although Gillon is only prepared to acknowledge that this “simplistic stereotype” is held by some doctors he introduces a quote from Levinsky as follows:

Levinsky probably writes for many doctors in stating:..
'physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations. In caring for an individual patient the doctor must act solely as that patient's advocate, against the apparent interests of society as a whole, if necessary' (*ibid.* p.115).

It would seem reasonable to assume that as this value is central to both the codes of the GMC and BMA and is enjoined on all doctors, Gillon's assertion that only some doctors hold to this value is probably an understatement and his recognition that Levinsky's statement reflects the view of many doctors, is closer to the reality. Nonetheless, in presenting his argument Gillon raises an important point with regard to the actual practice of doctors around this particular tenet of formal, explicit principlalist medical ethics. Here is an indication that the profession in its proper desire to reassure the public, its potential and existing patients, of the trustworthiness of their doctors may prefer to conceal a reality of practice behind a more acceptable medical myth. It has already been noted that part, perhaps a significant part, of the function of medical ethics is to "legitimise to society the authority and power of the medical profession" and in this, as ten Have and Freidson note, the ethical values espoused must meet with the approval of the wider society (ten Have, 1988, p.28; Freidson, 1970, p.243; Bullough, 1966). Thus, it appears that in its formal ethical code, the profession focuses

on the reassuring ideal of patients' interests taking precedence over all other considerations, although being aware that other values, ones that it perceives as possibly less acceptable to the client population, guide actual practice. However, it is not just patients or potential patients who may find it unacceptable for a doctor to be required to move away from ethics that focuses on care of the individual patient and towards a wider common good ethics. Doctors themselves have concerns about this change of emphasis and it is here that they perceive the possibility of conflict if they combine their role as practitioners with that of manager

Leaving aside matters relating to individual life-styles and confidentiality which, although important, are not especially relevant to this discussion³⁶, the point of concern arises around questions of overt health care resource allocation decisions, or rationing:

For the doctor in a clinic... 'abstract' choices between groups of people are not relevant... For the planner, however, consideration has to be given to the circumstances in which two patients will benefit from treatment when there are only sufficient resources to treat one of them (Lewis & Charny, 1989, p 28).

³⁶ For example, a doctor may be faced with a patient presenting with a sexually transmitted disease and at that point questions of the needs of the individual patient, including their right to confidentiality, may conflict with what the doctor sees to be a duty to at least some members of the wider community.

This is the commonly held view - doctors care about the best treatment for the individual patient whereas managers, or planners, have to care about how to share resources across whole patient populations. To ask doctors to take on the management role of direct resource allocation decision-maker is to compromise their integrity. As one doctor is reported to have said "it's not my job to look down the road and see where we'll end up if the spending isn't slowed down... Somebody else is going to have to tackle that problem. My job is to do the very best I can for each of my patients, and the cost be damned". And this from an American family physician (Nelson & Nelson, 1995, p.62). Yet, as Gillon powerfully illustrates with his clinical examples, doctors themselves are constantly, on a day to day basis, faced with questions of how to use resources most effectively. Two forms of the same antibiotic used in the treatment of acne, the more expensive of the two "somewhat more likely to be effective...and even less likely to have nasty side-effects"; if the overriding consideration is what will be the best treatment for an individual patient then the more expensive antibiotic should be the drug of first choice. According to Gillon, GPs routinely start a treatment with the cheaper antibiotic, only moving on to the more expensive if the condition is unresponsive (Gillon, 1988, p.126).

In fact, the need to consider the wider cost-benefit implications of individual treatment decisions has been a reality for doctors for

many years and certainly from the early days of the NHS. Despite the fact that the NHS had been created with the express purpose of removing financial considerations from treatment needs, “a comprehensive Health Service...to ensure that every man, woman, and child can rely on getting all the .. treatment .. which they need..; that what they get will be the best medicine..; that their getting them shall not depend on...any...factor [other than] real need” (Sir John Hawton, quoted in Hoffenberg, 1987, p. 10), very quickly this ideal proved unrealisable. Doctors soon discovered that the system designed to free them from all financial inhibitions had in reality turned them into the “State’s agents for rationing” scarce health care resources (Klein, 1995, pp.33, 36).

More to the point, a system for the rationing of health care has been part of the NHS virtually from day one. Firstly, in the general practitioners historic role as ‘gate-keeper’ to the secondary layer of NHS services, such as appointments to see a consultant. And secondly through the use of waiting-lists. Although in recent times the waiting-list has become somewhat infamous, in reality it is a well-established device for rationing NHS care (Klein, 1995, p. 229).

Despite this traditional, and even obvious, requirement to take into account needs other than those of the index patient (the patient before the doctor at any one time) there is a decided reluctance on the part of practitioners to admit such a scope of interest. Hoffenberg suggests a reason for this reluctance. He notes that although doctors

are responsible for generating the bulk of NHS costs, they have not for most of the life of the NHS been called to account for their spending decisions (Hoffenberg, 1987, p.10). Part of the reason for this lack of accountability was that doctors hands were not actually on the purse strings. Their relationship to the financial implications of their decisions was at a remove. They were not, in the phrase used by Harrison *et al*, “formally responsible” (Harrison *et al*, 1992, p.128), for managing resources. Others had the job of standing between them and the money and it was those others, not the doctor, who had to account for the way resources were used.

Aaron and Schwarz (1984), in their comparison of health care resource allocation in both the United States and the United Kingdom, described the way that within the British system doctors would present to their patients what was in reality a cost-based decision as if it were guided by clinical needs alone (pp.24,25). They noted that, for example British GPs, as gate-keepers to further levels of treatment, accepted and operated a dialysis rationing system based on a tacit but widely understood cut-off age. Thus, when an older patient presents with a condition for which dialysis would be the optimal treatment rather than referring them on to a consultant the GP would tell the patient, or more likely their family, that “nothing more can be done” other than “keeping your mother comfortable”. In this way, the doctor maintained her or his professional integrity, the patient and the family were re-assured by the kindness and care

provided, and a scarce NHS resource was saved for a “better” use (pp.101,103,107). Thus, “political problems are, in effect converted into clinical problems” (Klein, 1995, pp.77, 78). Doctors’ acquiesce in this arrangement although it clearly works against the best interests of individual patients.

The evidence indicates that all concerned were, to a greater or lesser extent, aware that the reality of practice differed from the theory and the explicit ethical commitment. Patients had some idea that certain limited resources were allocated on criteria other than health needs and the operation of waiting lists, a device Harris has termed “covert euthanasia” (Harris, 1985, p.86), has long been recognised and accepted, albeit grudgingly. Doctors have lived with this conflict of interests: the needs of the individual patient against those of the wider society. However, they have done so covertly and in a “hands off” way. This has allowed both doctors and patients the reassuring illusion that the needs of the individual patient are always paramount (Klein, 1995, p.78).

The NHS Reforms have changed that hands off approach. Holding clinicians to account for expenditure they incur was seen as “the last unmanaged frontier in the NHS” (Hunter, 1994, p.6). “Individual doctors are now expected to be more accountable for the financial consequences of their clinical decisions”. This, in turn, “leads to a change in style of medical practice” (Hoffenberg, 1987, p.11). Like the Hippocratic oath, the principle of patients best

interests has been thought of as vital to both the doctors' and patients' image of what medicine is all about, another element in the myth of medicine. Doctors are no longer able to operate a covert rationing system and patients are much more aware that the doctor will take note of the cost implications of their treatment. While some practitioners recognise the need and value of making their long-established rationing role more overt (Ambury, 1998), others feel this has undermined the doctor-patient relationship.

Clinical Autonomy

Alongside the principle of patients' best interests stands an equally important concept in the medical mind, one that underpins all medical practice and which the profession, as I have already shown, fought long and hard to establish. It is the principle of clinical autonomy. Irvine has described it as the profession's "central doctrine" (Irvine 2000).

Clinical autonomy has two aspects. The one most obvious to patients is "in the consultation, the central professional act" (Irvine, 2000). It is the freedom of individual doctors to prescribe whatever treatment she or he considers appropriate for "their" patients. The second aspect is about professional control. Collective professional autonomy focuses on "professionally-led regulation" (Irvine, 2000), the profession's right to set and maintain its own standards free from outside interference, "no accountability or strings attached" (Irvine, 2000). The introduction of a more proactive management system

within the NHS was seen to threaten both aspects of this core value (Hunter, 1994, pp.7-8).

However, when the basis of clinical autonomy is scrutinised, the principle appears less than morally tenable in the light of modern medical practice. Such a scrutiny must begin by understanding how and why this principle has come to figure so prominently in medicine's value-system. Freidson's (1970), study on the professionalisation of medicine shows the importance of independence, or autonomy in the establishment of professional status. He identifies this as the hallmark of a profession. Based on that criterion medicine, with its ability to command clinical autonomy as the right to regulate its own standards, is the quintessential profession. Whilst professional self regulation was all important to the profession, it also saw the control over its patients as another mark of its professional status.

Lawrence (1996), describes in some detail the way in which medical men established control over their work and their patients, gaining the authority to define "good knowledge" and acceptable practice. The process was "a culmination of ongoing relationships" and out of this process, hospital medicine emerged in the early-nineteenth century.

Hospital men, their pupils, and their colleagues, constructed medical knowledge in the eighteenth century through their behaviour, what they said about health and

disease.....Having the power to determine what, out of all a sick person's experiences and corporeal names, had considerable significance lies at the heart of medical authority .. Locating that power in hospital men and in medical men of science made modern medicine (pp.20, 28).

Once gained, medical men would be disinclined to let both aspects of that status enhancing power, collective and individual autonomy, go.

The determination to maintain control meant practitioners had to keep within the bounds of acceptable behaviour as determined by the elite groups the profession aspired to join. "Thus, in order for hospital men to establish themselves as a professional elite....they had to construct new medical ideas and methods....all the while paying *careful attention to the nuances of knowledge in lay society*" (Lawrence, 1996, p.21 emphasis added). For, as Freidson observes, the profession was hardly likely to have been granted its special position by the elite society which it saw as its natural home "if the profession did not represent or express some of the important beliefs or values of that elite" (Freidson, 1970, p.73). Thus, the "idea of a friendly, familiar doctor "being there" assumed a key role in deep-rooted ideals of good medical practice" (Porter, 1997, p.670; Bury, 1997, pp.77,78).

Nowadays, however, for the vast majority of patients the reality of that image is long past. Whereas in the days before the huge advances in biological science "medicine was a form of healing that

primarily involved and inevitably required a relationship between a healer and a patient”, today “the new medicine can work on patients who don’t know their doctors or don’t like their doctors” (Lantos, 1997, p.4). And the structures within which most health care is now provided mean that patients will see many doctors but rarely if ever their “own” doctor. Medicine is now a complex multi-speciality operation, provided by different professionals within a vast organisation. Against that background it is difficult to justify the doctors’ claim to a special right to clinical freedom. Shall each individual specialist be entitled to claim total freedom to treat a patient without any responsibility to consult colleagues and take advice? A recent case considered by the GMC highlights the dangers of this isolationist approach. The doctors involved refused to heed advice from colleagues and despite serious misgivings as to their competency they were allowed to continue their apparently unsafe practice.³⁷ Notwithstanding guidance from the GMC which encourages doctors to “recognise the limits of your professional

³⁷ The case involved cardiothoracic surgeon whose practice appeared to have led to a significantly higher number of deaths in children on whom he operated than was the case with other similar operations performed by other surgeons. A consultant anaesthetist who considered the surgeon’s practice unsafe reported the matter to the GMC. Two of the doctors involved, who by the time of the case had both retired, were struck off the register. The third has been allowed to continue practising although banned from operating on children for several years. His employing Trust has now sacked him. The whistle blowing doctor has moved abroad believing that following his action he had become something of a pariah and would not find employment in this country.

competence” and “be willing to consult colleagues” (GMC, 1995, p.2), clinical freedom continues to be a jealously guarded right.

As Klein has astutely observed, fundamental contradictions were built into the structure of the NHS (Klein, 1995, p.26). One of the most fundamental of those contradictions arose from the reality of a system created on socialist collectivist principles, yet dependent for its success on a profession whose stated core ethical value is highly individualistic; medicine operates around a one to one relationship; the needs of an individual patient met by the clinically autonomous individual doctor. Indeed, it was thought at the time that such obviously conflicting sets of values were irreconcilable (Webster, 1997, p.25). Nevertheless, as has been shown, the conflict, although theoretically fundamental and important, has proved in the reality of ongoing practice to be rather less significant. Having gained “a monopoly of legitimacy among health service providers” within the NHS, the medical profession, or at least the more powerful elements within the profession, appeared content to work within and participate in running, the new structure (Klein, 1995, pp.25,75). Although, through its various representative organisations, the medical profession has raised the voice of protest on many subsequent occasions, the areas of concern have generally focused around matters of professional self interest rather than more immediately patient-centred issues (Klein,1995, p.69).

And yet there remains a conflict inherent in this situation. “The medical imperative of maximising the input of care for the individual patient was... at odds with the financial structure of the NHS” (Klein, 1995, p.76). But “the price of preserving clinical autonomy - the right of individual doctors to do what they thought right for individual patients - was accepting the constraints of working within fixed budgetary limits” (Klein, 1995, p.75). Irvine concurs in this judgement:

The State, chronically strapped for cash, encouraged the medical profession to ration care on its behalf through the doctrine of care according to clinical need - in plain language, waiting lists. Doctors, the reasoning ran, would be more trusted by the public than politicians to make decisions on clinical priorities. As a result doctors in the UK retained far more clinical freedom than for instance, their American colleagues (Irvine, 2000)

If putting the best interests of the patient first is the moral principle at the heart of clinical autonomy then clinical autonomy cannot be bought at the price of accepting “fixed budgetary limits”. The doctor’s decision to offer a patient treatment must not be limited by the need to work within the constraints of a budget. Yet, the medical profession accepted the principle of budgetary constraints as the price for maintaining clinical autonomy. “The doctrine of clinical

autonomy continued to reign supreme” (Hunter, 1994, p.14 quoting Moore).

But while doctors may, understandably, try to circumvent efforts to limit their clinical autonomy (Hunter, 1994, p.10 quoting Caper), that position cannot be sustained on the basis of a moral argument familiar to, or widely accepted by, those outside the profession. Its purpose and impact is open to question and reassessment (Nelson & Nelson 1995, pp.61-62). The emphasis on the new managerialism within the NHS creates the framework within which such a questioning and reassessment might at least begin with the potential to benefit patient care, though such a positive outcome is by no means guaranteed (Hunter, 1994, pp.18-20), as the experience of one “new style” manager illustrates.

The audit manager interviewed for my research, and to whom I have already referred, had direct experience of the lengths to which doctors would go to safeguard their clinical freedom. The manager’s job involved trying to devise treatment protocols, that is guidelines for best practice for general practitioners. This meant first asking GPs to describe their treatments for a given condition and then comparing outcomes. The aim was to find the most effective programme for a range of common conditions and set these out as guides for future practice. The extreme reluctance of virtually all the GPs to open their particular treatment methods to any kind of scrutiny - “many of them won’t even talk about such things with their

colleagues let alone me as an outsider” - made it almost impossible to gather the data on which the project depended. Protecting clinical freedom was the GPs stated reason for refusing to co-operate with the scheme, even though what was being proposed had the potential to offer benefits to patients.

Doctor-Patient Relationship: Passive Recipients or Active Consumers

Closely allied to clinical freedom is perhaps one of the most powerful myths within the NHS, and Western medical practice in general, namely, that of the doctor-patient relationship. “The model personal physician or familiar doctor looms large in the public imagination, yet has the ring of myth... This idea of a friendly, family doctor “being there” .. medicine characterised not by perfect health but by a desirable clinical relationship” (Porter, 1997, pp.69-70). All the other issues explored in this chapter rest on the fundamental assumption of the sanctity of that relationship. Many of the concerns raised regarding the changed nature of the role of the doctor within a more managerialist NHS centre around the potential damage to this vital and yet delicate relationship. The fear expressed is that by emphasising standards, quality control, and citizens’ rights the interaction changes from the traditional doctor-patient relationship to something closer to that of customer and service provider. Doctors’ at least, appear to find this change disturbing and even dangerous. Yet once again, when the nature of the “traditional doctor-patient

relationship” is explored in greater detail, we find that it is the mythical element rather than the day to day reality of doctor-patient interactions that is being defended and protected:

In fact, while the term “doctor-patient relationship” has widespread currency, it probably emerged originally from medical circles, referring to the claims of doctors to have a special “relationship” with the patient. Put this way, the term seems more ideological than descriptive, rendering clinical judgement and medical claims over the patient benign, and conveying a 'medico-centric' image of trust and public acceptability. The use of the term in the medical sociology context may have always been more problematic than recognised (Bury, 1997, p.77).

Alongside the trusting, caring components of the doctor-patient relationship there are other aspects that raise ethical questions regarding the value of maintaining the traditional approach to this interaction.

In the days when medicine had very little to offer apart from care and comfort, the relationship between the doctor and patient was probably the most important aspect of medical practice. “The rituals of scientific, diagnostic medicine spelt out the message that care was being dispensed, and hence strengthened the bond between physician and patient...Curing remained a subordinate consideration...A sympathetic, caring manner was therapeutic in

itself" (Porter, 1997 pp.680, 682; cf. Porter & Porter, 1989). As medicine became more scientific, reductionist, and mechanistic it became less and less important to see patients as persons, or understand them as social beings; unique individuals. The doctor-patient relationship moved into its modern phase with the doctor as expert to be obeyed without question, and the patient as passive beneficiary of the professional's expertise. With "real" medicine to hand doctors no longer had to play the game of soothing and pacifying, now that they could fight and win against disease the role for the patient was reduced to acquiescence. "Medical authority, medical institutions and medical science and technology... combined to render the patient paradigmatically passive, with the doctor on top - the position preferred by the medical profession for treatment" (Porter & Porter, 1989, p.12). The patient's view was seen as immaterial, marginal to the practice of medicine, too subjective to have any credibility in medical decision-making with its new emphasis on objectivity (William & Popay, 1994, p.121). Their role was restricted to that of compliance with "Doctor's orders" (p.57).

This new interaction was, as it continues to be, referred to as a doctor-patient relationship. It thereby carried all the old images of humanity and a fair degree of mutual respects based on the recognition that each party to the relationship had something valuable and worthwhile to contribute. Nevertheless, the reality of the relationship had fundamentally changed. By and large patients

seemed prepared to accept the changes in order to receive the obvious health care benefits the new scientific medicine appeared able to deliver.

However, medicine has again moved on. Nowadays, not only is medicine a highly technical endeavour with many of its procedures involving patients in considerable risk and potential long-term problems (Sharp, and Fade, 1998), but it has also proved unable to meet some of society's most challenging health care needs. Wendell (1992, p.72), points to the cultural myth of the sick body as that which can be controlled. Modern Western medicine has long played into this myth: doctors and patients enjoying the image of medical hero curing all diseases and saving lives. The realisation that not every disease is amenable to cure, that some conditions must be lived with, has obliged "patients to a more active involvement" in identifying and meeting their own health needs (Kelleher, 1994, pp 109-112; Wendell, 1992, p.73; Harrison, 1993, p.211).

Furthermore, there is a significant body of evidence to show that far from the objective, scientific view medicine claims as its basic model the subjective values and prejudices of doctors can impair the quality of their decision-making in the case of particular patient groups. Thus, in 1979 Jeffrey reported on his study of what was then termed Casualty departments, now known as A&E. He found doctors working in these departments classified certain patients as "rubbish". Those patients were generally treated less well than

patients doctors viewed as medically interesting or challenging (Jeffrey, 1979, pp.249-254). Timmermans (1995), observing staff in emergency rooms in north American hospitals, found that they withheld "potentially beneficial treatment because of moral judgments (*sic*)". That is to say, judgements based not purely on medical conditions but also social position. Patients with socially valuable characteristics were considered worth treating whereas those judged of "low social viability", including "drunks and drug addicts", "might die a premature biological death" (pp.127-150). Timmermans was "discouraged" to find that the attitudes he observed appeared to have changed little from that found by Sudnow in a study he had conducted almost thirty years earlier (p.151). Likewise in the modern A&E department of hospitals in Britain, "arrogant" casualty officers still dismiss certain patients as "dross" and routinely deny them the treatment that would be offered to more acceptable patients (Ambury, 1998).

Doyal (1994), notes that many black and working-class women were given very little time and attention by a predominantly white, middle-class, male medical profession. "Women's own experience is devalued by comparison with that of doctors' expert 'knowledge'....As a result, female patients frequently become the passive victims of doctors' ministrations". And these ministrations often involved providing less effective treatment than that offered to men with the same conditions. Thus, in one English health care

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region research showed that men were 60 per cent more likely to be offered coronary artery bypass operations or angioplasty (pp.145, 148).

In this increasingly complex and even “messy” situation there is a growing need for doctors to “take their patients seriously....To see patients as active decision-makers” (Nelson & Nelson, 1995, p.62). Many patient groups have not waited for the medical profession to change its attitude, they have actively pursued a new model of that old relationship.

People living with life-threatening diseases began to question the medical orthodoxy. In the treatment of breast cancer, women became much more actively involved, taking responsibility for understanding the nature of the condition and the medical treatment offered. They then challenged and changed the traditional medical procedures, the result has not only been “a more ethical approach but also a more therapeutic one” (Doyal, 1994, p.152) With the arrival of AIDS in the homosexual community, a group of mainly young, vocal, men used to standing against the orthodox and the traditional, found themselves apparently beyond the scope of medical expertise. As a result of their insistence on active involvement in the management of their condition “the traditional idea of expertise was challenged, provoking a great debate on who was entitled to a seat at the table in a paternalistic medical set-up forced to become more democratic, accessible and client-friendly” (Porter, 1997, p.708).

Those with long-term disabilities, chronic illnesses, and conditions associated with ageing, have grown increasingly dissatisfied with the role of passive patient. Many actively seek knowledge about their condition, becoming experts in their own right. Rejecting the medical model that dominates much of the professional attitudes towards their needs, they have pioneered “totally new perceptions of themselves and the services that they need” (Finkelstein, 1993, p. 42; Bury, 1997, p.81; Williams & Popay, 1994, p.133; cf. Sidell, 1997, pp.10,12).

All this, together with the managerial challenges to medicine, suggests that a new type of doctor-patient relationship may now be emerging. It is one that has moved away from the passive grateful recipient model and toward a more active, involved, and information-demanding model. In other words, away from doctor-patient and towards doctor-consumer (Bury, 1997, pp.82, 106).

Although studies indicate that a more co-operative, less hierarchical relationship is likely to exist between the doctor and the private patient this has not been the experience of patients within the NHS (Silverman, 1987, p.57). Indeed, there are a number of objections to the idea that NHS patients are becoming, and should become, more active consumers. Most of the objections are, however, based on a rather limited and negative view of the concept of the consumer.

It is argued that moving to a consumer sovereignty model requires doctors to act, simply, in response to their patient's wishes and desires, thus taking no account of the doctor as "independent agents with professional and moral commitments" (Brock, 1993, p.58). Sorell finds the whole idea objectionable because "in consumerism....it is the customer who gets precedence;...and quite a lot of latitude...in pursuing and defending their own interests against providers...Consumerism is unconcerned with responsibilities of users or consumers to one another" (Sorell, 1997, p.75). And while Ranson and Stewart concede that viewing their client group as customers forces public organisations to look outward and at least consider those who use their services, they nevertheless, believe the emphases of consumerism "inadequate"; focusing too much "upon the individual in receipt of a service, rather than on the citizen as an active participant in the polity" (Ranson & Stewart, 1994, p.19). Similarly, Paton, stressing the choice factor in the consumer model, suggests that the notion of the patient as consumer can never be more than an artificial device without any substance, a mere "bureaucrat's buzz-word" (Paton, 1992, pp.14-19).

The complexities and weaknesses of the concept of "the consumer" (Gabriel & Lang, 1995, pp.2-3), are perhaps only matched by the complexities and weaknesses of the concept of "the patient", which is no longer able to serve the best interests of those in need of health care. The trust at the heart of the traditional doctor-

patient relationship is no longer appropriate. Patients must now deal with a virtual army of specialists, few if any of whom will be known personally to the patient. "Trust which might have gone to a doctor long known to the patient goes less easily to a team of strangers, no matter how well meaning or expert" (Bok, 1989, p.233; Kelleher, 1994, pp.114-5; cf. Little & Fernside, 1997). The values of the patient seem quite divorced from the expert system that is modern medicine, thus, people feel the need to take a much more positive role in protecting those values. In the case of the Bristol cardio-thoracic surgeons (see footnote 13) many parents of the 29 young patients who subsequently died during or following surgery, condemned the fact that as a matter of established medical policy they were denied full information on the risks involved. Without that information, they argued, they were not in a position to give "informed consent".

And while consumers can be as demanding and selfish as any patient, the rise of the ethical consumer demonstrates that consumerism has moved on. Now the distinction between concepts of "right and wrong, damaging and beneficial, useless and useful, needs and wants" has become important in many areas of consumption (Gabriel & Lang, 1995, p.171). A more explicit "market relationship" can potentially make doctors more careful about how they treat their patients, and patients more careful in selecting and evaluating their doctors (Bury, 1997, p.105). The

responsible consumer can operate within the NHS as ethically and effectively as they now operate in many other areas (Descombes, 1999, p.191f).

Summary

Exploring the perception of a clash of values between doctors and managers around ethical principles has shown up many areas not of conflict, but of concord, albeit perhaps reluctant and maybe even often hidden or unrecognised. The principles of good management are as important to the medical practitioner whether in private practice or in the small GP partnership as they are to people operating in any other area of business. Although doctors may not want to admit it, these principles have equal value to the care of patients within the NHS. Nevertheless, where conflict exists between the two, it has arisen around those values doctors are at such pains to defend as central to good practice: clinical autonomy and the doctor-patient relationship. But the centrality of these values arises from their link to the traditions informed by the medical ethos rather than to the four principles of modern medical ethics; their significance lying more in what they tell the profession about itself - the profession's self-image - than about ethics of patient care. Furthermore, this analysis suggests that it is the management values of accountability, consumer-oriented provision, and the common good that may actually be of more benefit to patients as a whole.

PART TWO

Case Study and Analysis: Testing the Theory

The historical emphasis in the first part of this study has allowed me to develop two main points. First, defining and drawing out the subtle but important distinction between the concepts of ethos and ethics. Second, using the particular example of the medical profession: tracing the development of the medical ethos - that belief in itself as a noble, superior profession, of special dignity and worth - and demonstrating the relationship of a profession's ethos to both its explicit formal statements of ethics, and its implicit ethics of everyday thinking and practice.

In order to test the validity of the theoretical material, I now introduce a specific case study of the response of the profession to the reforms that began with, and followed on from, the Griffiths Report. This study has two elements. It begins with secondary historical data that looks back to the early 1980s when the reforms were devised and introduced and sets out the reactions of both the medical profession and the new NHS managers.

However, that data alone would have offered an incomplete case study. This research was undertaken while the impact of the Griffiths and post-Griffiths reforms were still unfolding. The case study would have lacked depth if it had ignored this living and lived experience. Thus, following on from the secondary data the case study moves to primary empirical interview data. It presents the

voice of individual doctors as they faced the dilemma of introducing management values and practices into the heart of clinical practice. Did this new situation create a conflict? What values and beliefs informed their thinking? Does the hypothesis offer a valid interpretation of the GPs thinking and action around their decision?

Chapter 5

A Case Study: Griffiths and Beyond

Clinicians carry with them a culture in which 'management' has been a dirty word - the subject of ridicule - where, for example, often the least influential consultants were elected to the position of Area Medical Officer.

Huxham and Bothams, 1995, p. 31

Introducing the Case Study

This case study, or paradigm example, will demonstrate how my hypothesis relates to a particular historical challenge, namely, the reforms that followed from Griffiths and, beyond that, Enthoven.

Through the historical data will first be heard the voice of the leadership of the medical profession including the representatives of general practice as the branch of medicine that has been the special interest of this study. This material is taken from mainstream authoritative sources including the BMJ, the Lancet, a study by a former chairman of the BMA who was closely involved with process of formulating and presenting the profession's position, and an address by the president of the GMC, Sir Donald Irvine. The voice of the "ordinary" individual doctor, including their dissenting opinions, will be heard later in the study.

The questions addressed in this first part of the paradigm example are: how did the leadership of the profession present the reforms to their members? What issues did it emphasise? What response did this encourage from the body of the profession? How were these matters presented to the public?

Next, I refer to historical data that sets down the views of the new breed of managers the reforms brought centre stage in the NHS. What was their attitude to the reforms and how did this compare with that of the medical profession? Answering these questions will help pin-point the impact of those underlying attitudes and beliefs that I have identified as the hallmark of the medical profession's ethos, namely, the sense of itself as noble and superior, that informs its thinking and practice. The main source for this section will be Strong and Robinson's (1990) ethnographic study of the new NHS managers in which the researchers interviewed a large number of these managers from across the UK.

Chapter six onwards focuses on primary data gathered directly by interview with individual general practitioners. It offers a first-hand account of their responses to the clear cut choice presented by the reforms, namely to become fund-holders or stay as non-fundholders

Interviewing both fundholders and non-fundholders allows me to present the different positions taken by individual doctors to the new management and internal market in the NHS. Fundholders offer their rationale for accepting markets and management; then non-fundholders present their arguments for rejecting that path. The empirical data, thus, offers a further powerful test of the hypothesis. What values and beliefs informed each GP's decision and how well does the hypothesis account for those decisions?

General Management and The Internal Market

This section begins by setting out the management reforms initiated by the government of 1979. The main focus is on the responses to those reforms of the two main groups affected by them, namely managers and the medical profession. Finally, it analyses those responses in the light of the thesis hypothesis.

As noted above a wide range of sources have been consulted for this section, however, I have also chosen to focus on a few main texts for the authority of their opinions, observations, and assessments. Griffiths (1983; 1992), figures prominently as the author of the report that provided the basis for the reforms; Lee-Potter's (1997) account of the impact of the reforms on the medical profession carries great weight since he was closely involved at the highest levels of the profession, including a period as chairman of the BMA during the 1990s; the same must be said of Irvine, speaking as President of the GMC; the voice of the new breed of NHS manager is heard through Strong and Robinson's (1990) use of direct interview, observation and listening, capturing, in their phrase, "the vision that inspired most of them" (p.65).

Although the name of Griffiths is still most commonly associated with the changes that took place in the NHS during the 1980s and 90s, the reforms were the result of a combination of two sets of ideas new to the NHS: general management and the internal market. The former arising from the report of Roy Griffiths and his team; the

latter the result of work done by the American academic Alain Enthoven. Reference has already been made to both these elements but they will now be discussed in greater detail as background to the main focus of the chapter; the case study material.

In 1983 the Secretary of State for Health, Sir Norman Fowler, invited the supermarket head, Roy Griffiths, to lead a team of four businessmen to advise on an effective management structure for the NHS. Within just six months the committee produced its report. “It proved the most unconventional NHS report of all time” (Timmins, 1996, p.409). Rather than a wordy tome running to hundreds of pages the team produced a twenty-three page³⁸ letter addressed to the Secretary of State. This document, the Griffiths Report, set out in clear, simple terms “what we would do in his [the Secretary of State’s] place”. It offered seven pages of recommendations. As a prelude to these recommendations the Report stated:

we believe that a small, strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS) to ensure that responsibility is pushed as far down the line as possible, i.e. to the point where action can be taken effectively (Griffiths, 1992, p.62).

³⁸ This figure varies according to which account you read falling somewhere between twenty-two and twenty-five pages. My figure is based on Sir Roy Griffiths’ own count.

Thus, the intention was to move the NHS away from the 1974 consensus management model³⁹. According to Griffiths, this model had produced weak and fuzzy management. The team noted that individual management accountability could not be identified, it was difficult to know who was in charge. “If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge” (Griffiths, 1983, p.22; cf. Harrison *et al*, 1992, pp.44-45; Strong and Robinson, 1990, p.4ff).

Overall, management lacked thrust, so change was very difficult to secure. “There is no driving force seeking and accepting direct and personal responsibility” (Griffiths, 1983, p.12). Furthermore, Griffiths was surprised to find an almost total lack of performance orientation. Thus, he noted that:

rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation...is extremely rare (Griffiths, 1983, p.10; Griffiths 1992, p.62).

Arising from this assessment the Team’s recommendation was a positive move towards a general management model. At all levels there were to be general managers “responsible for making things happen” (Klein, 1995, p.147), “one individual who has ultimate

³⁹ For a discussion of consensus management see chapter 3 sub-section 1969-1979

responsibility and decision-making power over all staff within their unit” (Tilley, 1996, p.292). Griffiths envisaged a clear line of command stretching from Whitehall down into every unit of the hospital service (Strong & Robinson, 1990, p.20); the general manager would not take the parochial view of the specialist, as typified by the thirty thousand doctors, but rather their focus would be integrationist and “global” (Strong & Robinson, 1990, p.24).

In order to implement a clear line of command Griffiths advised the creation of a NHS Supervisory Board with strategic responsibility. This Board to be made up of the Secretary of State, the Minister for Health, the Permanent Secretary, the Chief Medical Officer, and the Chairman of the next element in the chain of command, namely, the Management Board, and two or three non-executive members. The Management Board itself, “the small strong general management body,” was to be responsible for implementing the strategy devised by the Supervisory Board. effectively taking over all the management responsibilities formerly undertaken within the Department of Health and Social Security.

General managers were to be appointed at every level of the service down to each separate Unit. It was these individuals who would be personally “accountable for the performance of their organisation”; responsible for making sure that it met the objectives of the local health authority, itself working under the overall strategy set by the centre (Griffiths, 1992, p.66; Harrison *et al*, 1992, p.44).

Griffiths envisaged health care professionals taking on these new roles as general managers. Of his management reform programme he says:

I personally believed and intended...that the doctors and nurses...would...take the top management positions. They would become the best of all managers, T-shaped managers with an in-depth professionalism accompanied by the broadening of management experience (Griffiths, 1992, p.65).

The traditional rigid separation between various roles was to be broken down, “the managers and clinicians of tomorrow were to be crossbreeds” (Strong & Robinson, 1990, p.72).

However, as the Team set out on their inquiry, they encountered considerable ill feeling from health care professionals. In the words of Timmins “all hell broke loose” (Timmins, 1996, p.408). Once the report had been published the situation did not improve. Doctors perceived the changes as “altering the balance of power between the professional staff and the managers”; in their view, Griffiths “wanted the NHS to be run like Sainsbury’s”. Although at first they were merely rather wary, in time they came to see the managerialism Griffiths had started as posing a significant threat to the NHS. Just as they had once opposed the creation of the NHS on the grounds that it would destroy the doctor-patient relationship, they now opposed general management on the grounds that it would destroy the NHS

and with it the doctor-patient relationship (Klein, 1995, p.150; Lee-Potter, 1997 pp.32,146; cf. Timmins, 1996, p.410).

Despite the concerns of the professions, within a year the government had implemented virtually all the main recommendations. And, after all the preliminary fuss and anxiety, everyone appeared to settle into the new arrangement (Strong & Robinson, 1990, p.27). However, in the words of Griffiths: “just as general management was finding its effective feet, the level of decibels both in the Health Service and on the political front scaled new heights and Margaret Thatcher in early 1988 decided to establish her own Review” (Griffiths, 1992, p.66).

In his “biography” of the welfare state, Timmins describes the heights to which the decibel level rose at that time. In just four pages (Timmins, 1996, pp. 454-457), he sets out in graphic detail the “spiral of despair” that the NHS had entered. During that period, 4000 beds were closed, nurses took strike action, GPs placed advertisements in newspapers telling their patients that cash shortages meant treatment would not be available, and the presidents of the senior Royal Colleges issued a joint statement warning the government that the NHS was in danger of collapse. According to another authoritative voice “doctors were becoming angrier and angrier...consultants were intensely frustrated...and their junior colleagues had become seriously militant” (Lee-Potter, 1997, p.44; Klein, 1995, p.177). Against this background of anger and despair

the Prime Minister announced, during an interview on a current affairs television programme, “our own enquiry” (Klein, 1995, p.176, 181; Allsop, 1995, p.157).

In 1984, even as the Griffiths Reforms were being implemented, another short review of the NHS was taking place. Alain Enthoven, Professor of Health Management at Stanford University, had been invited by Nuffield Provincial Hospitals Trust to cast his expert eye over the Service. The result of his analysis was a paper entitled *Reflections on the Management of the NHS* (Enthoven, 1985) in which he proposed the creation of an “internal market” within the NHS. Enthoven’s ideas were already in circulation as the Thatcher review began.

The basic idea behind the internal market involved the separation of the purchase of health care from the producers of health care, the so-called purchaser/provider split. The intention was to increase efficiency and cost sensitivity throughout the Service by introducing a new element of competition into it thereby making more effective use of the available NHS budget (Paton 1996, p.1ff). Managers would be able to buy health care services from the producers who offered the best value for money. This carried the assumption that such a judgement was possible. Griffiths had noted the paucity of information in the area of costs and quality of output. His management reforms were intended to address this lack and clearly, Enthoven’s internal market would depend on, as well as encourage

attention to these areas. Once health care providers realised that their services would only be purchased if they could be seen to offer “value for money”, the belief was that this would concentrate the mind wonderfully and they would find ways of costing and evaluating their products.

This type of radical thinking appealed to the political minds⁴⁰ brought in by Mrs Thatcher to join her in a review of the NHS. In Paton’s assessment:

The origin of the NHS reforms lay in the desire by the...Prime Minister to move from the defensive to the offensive about health policy and to change the terms of the debate from one about levels of funding to one about levels of technical efficiency. This was the context in which the market evolved as ‘the answer’ (Paton, 1996, p.332).

However, despite the appearance of a clear, almost pre-determined course for their deliberations, the Cabinet Committee undertaking the review actually pursued a somewhat uncertain path. Griffiths recalls that:

It started out by seeking to examine new methods of funding the NHS...moved abruptly from this theme [and] then switched to building on the existing management reforms and

⁴⁰ Four members of the Cabinet: Nigel Lawson and John Major. Treasury: John Moore and Tony Newton. DHSS (later DoH). The latter two were replaced by Ken Clarke and David Mellor. Sir Roy Griffiths and a member of the Prime Minister’s Policy Unit, were invited to attend this Cabinet Committee’s meetings on a regular basis (Klein, 1995, p.184).

seeking to inject more competition and choice into the service

(Griffiths, 1992 p.66).

Klein describes the process as “a singularly rudderless operation” that “tacked rather erratically between different options” (Klein, 1995, p.188). The end product of all these uncertain deliberations was the White Paper *Working for Patients* (DoH, 1989).⁴¹

The Response of the Medical Profession

The medical profession was greatly angered by these moves not least because the result of the review was not a Green Paper, a document for consultation, but a White Paper, virtually presenting the intended changes as a *fait accompli*. There was considerable chagrin within the leadership of the profession that it had not been formally consulted by the Committee during its review. This intensified when it was not invited to discuss the findings before the precise nature of the reforms were decided upon. The intensity of feeling roused by the process of implementation is revealed in the emotive language used by Shock (1994) - himself a doctor and former rector of an Oxford College - in a speech he gave to doctors' leaders and later printed in the BMJ. Looking back on the events of that time he described the process as “blitzkrieg with little consultation, indeed not much discussion...It was almost a textbook campaign. Particularly to be admired was Panzer General Clarke's

⁴¹ For brief details of elements of *WforP* see chapter 3 sub-section 1979-1993.

[Kenneth Clarke, Secretary of State for Health] handling of the decisive weapon, money”.

According to Shock (1994), whilst the profession would have anticipated an attack from a left wing government it was “thrown into confusion” by this attack from a government of the right. Despite any initial confusion, it quickly recovered and over an 18 month period mounted a “spirited challenge” to the White Paper. An editorial in the BMJ referred to “anger and bitterness”, a “near hysterical atmosphere” and “acrimonious turbulence” as doctors voiced their protest (BMJ, 1996). Butler (1993), described the “sceptical and even hostile views of doctors”. Gladstone and Goldsmith (1995), specifically identified the medical profession’s opposition as “Consultant-led”. The BMA, traditionally recognised as representing the voice of the general practice branch of the profession, saw its membership rise to the point where it virtually became the voice of the whole profession with three-quarters of doctors joining its ranks (Lee-Potter, 1997, p.87). Thus, when it launched its campaign against the reforms it did so for the profession as a whole (BMJ, 1989; Klein, 1995, p 185). Later it wrote to all GP practices urging them not to join the fundholding scheme, warning that supporting the reforms would create a divided health service with hospital against hospital and GP set against GP (BMJ, 1990).

The BMA also ran a £2.5 million advertising campaign⁴² that showed the public the profession's opposition to the reforms. This included a poster that read: "What do you call a man who ignores medical advice? Ken Clarke". This wording carried a message that the profession knew would be well understood by the public, namely that doctors had advised against pursuing the reforms and by ignoring this medical advice the government's approach would be as damaging to the NHS as ignoring doctor's advice would to the individual patients. It sent out to GPs a poster for use in their surgeries. The poster read "SOS FOR THE NHS" (Lee-Potter, 1997, pp.90,92). There was also a leaflet for GPs to distribute to their patients. Among the questions the leaflet asked patients to consider was: "Do you want the cheapest treatment or what is best for you?" The message presented to patients was that the reforms would force doctors to give more consideration to costs rather than to care, that their clinical judgement would have to take second place to budgetary constraints.

Patients were clearly being told that the profession's opposition to the reforms was based on shared ethical principles: it was defending patients and the primacy of their care (Klein, 1995, pp.192-3). After describing the BMA's campaign Lee-Potter notes

⁴² The campaign has been described as "a classic of its kind that will go down in the annals of the advertising industry as a major success" (Lee-Potter, 1997, p.92).

that “there were not a few doctors who were uneasy about involving their own patients in the dispute” (Lee-Potter, 1997, p.91).

Despite all the opposition, in 1991 the NHS began operating with an internal market. The Service had entered a new era, the era of general management and the internal market (Baggott, 1988, p.188-194; Lee-Potter, 1997, p.14; Klein, 1995, p.131). It is worth noting Griffiths own assessment of the response to his Management Inquiry Report. In his view it:

was well received by government, but less well received by the professions...

He then observes...

I am given to understatement...

and continues:

The medical profession saw the report correctly as questioning whether their *clinical autonomy* extended to immunity to being questioned as to how resources were being used...[In their view] the *introduction of economics into the care of patients...was inimical to good care*. There was a deep-seated feeling that what distinguished the Health Service from the private sector or business or commerce was the very immunity of the Health Service from the supposedly corrupting influence of profit making...The report was never meant to be confrontational...What the Report did...was force the professions themselves to rethink their position. I pay tribute to them to the extent they have done this...The response two

years ago [1990] of the Royal Colleges to the latest government legislation was, even though in disagreement, considered and managerial to an extent which many would not have believed a few years ago (Griffiths, 1992, p.63, emphasis added).

General management and the internal market, would only work if managers and doctors could find new ways of co-operating with each other. As Hunter noted early on in the reform process:

If the support of the medical profession is not forthcoming...then it is unlikely that [the Reforms] will prove to be effective...Working with the medical profession to secure the required shift in clinical culture is...the only sure way forward (Hunter, 1993, p.38).

Nevertheless, whilst it was thought desirable, and even essential, to increase the involvement of doctors in management in order to achieve “organisational effectiveness in the quality of health care provided” (Ashburner, 1996 p.220), the early response of the medical profession to the package of reforms, *Working for Patients* (DoH, 1989) building on the Griffiths Report, indicated that this was very unlikely to happen. The profession saw this move as inimical to its core values and was not prepared to co-operate. As one commentator noted in the BMJ:

Contrary to what politicians think, the opposition of doctors to government reforms...may not be due to an objection to relinquishing power. A more enlightening explanation is that it

owes more to their desire to protect their core values against the onslaught of an untested economic model of public services (Smith, 1994).

The medical profession emphasised the unbridgeable gap between its values with their overriding commitment to the care of patients, and those of the “generalist” manager whose first loyalty must always be to the organisation and its success. Doctors would, in Klein’s phrase be “forced to subordinate the search for health to the search for solvency” (Klein, 1995, p.193).

Thus, Lee-Potter quotes The Joint Consultants Committee response to the proposed introduction of self governing hospitals:

These proposals inevitably change the prime aim of the management of these hospitals, from the provision of adequate care to the community as a whole to the financial success of the hospital (Lee-Potter, p.96).

It had been part of the aim of the reforms to address and deal with the complex problem of the relationship between general managers and those who possess a specialist skill that the organisation needs to use, for example doctors (Metcalf & Richards, 1993, p.123). Griffiths had envisaged that this cultural divide would be crossed by finding “new ways of fostering a partnership between professionals and generalists”, through encouraging more people who span the two cultures to take on dual responsibilities and translate the languages of the separate groups

(Metcalf & Richards, 1993, p.130). In the immediate aftermath of *Working for Patients* (DoH, 1989), that looked increasingly unlikely to take place.

One problem with the new approach arose from the fact that it was thought that these “crossbreeds” (Strong & Robinson, 1990, p.72), would need to be drawn from highly respected consultants with an instinct for management. Enthoven had observed that prestigious consultants command a high income and it would not be easy to entice them into management if that involved “a large drop in income”. This was a point the BMA repeatedly made to the government of the day (Lee-Potter, 1997, p.38).

The leaders of the profession saw the need to present a united opposition to the reforms. Any of their number who attempted to take on the new dual role had to face the opposition of their colleagues. Lee-Potter tells of one doctor, a member of the BMA, who found his situation among his professional colleagues untenable when in those early days he opted to become a manager:

Russell Hopkins who combined being a hospital manager with his clinical work was a management evangelist. He had practised what he preached by becoming one, but later struggled to maintain his influence and credibility within the BMA by becoming too closely identified with those seen as the forces of darkness - that is, Mrs Thatcher’s marketeers (Lee-Potter, 1997, p.76).

Russell Hopkins pro-reform stance was so out of tune with the rest of the profession that it became the subject of a question at prime Minister's Questions in the House of Commons. Hansard reports the following exchange:

Mr. Thorne : Will my right hon. Friend [The Prime Minister, Margaret Thatcher] find time to consider the remarks made by Mr. Russell Hopkins, the general manager of University hospital of Wales, Cardiff when speaking at the BMA conference at Swansea? He accused the BMA of spreading fear, apprehension and uncertainty among the chronically sick, elderly and infirm through its disgraceful publicity campaign. Will my right hon. Friend denounce such behaviour?

The Prime Minister : Yes, I am glad that some doctors and managers have the courage to speak out against the scare tactics which are frightening (*sic*) a number of patients totally unnecessarily. . . . The reforms are intended to bring about even better patient care. When we put them into operation, they will do just that (Hansard, 1989).

Another BMA member, Paddy Ross, who “spoke strongly for consultants to become involved in management in order to avoid being sidelined” was “well aware that [his views] could be seen as fraternalizing (*sic*) with the enemy”. Accordingly, “it was a hard time for Paddy Ross” (Lee-Potter, 1997, p.42).

As the following quotes from a doctor, a doctors' leader, and a former doctor turned DGM, will show, the focus of the medical

profession's opposition was presented in terms of the ethical conflict that doctors taking on the dual role would face. "The *moral integrity* of doctors is violated by the imposition of a managerial role which attempts to use them as means to particular organisational ends and, in so doing, limits their ability to fulfil their obligations to their patients" (Satz, 1996, p.80, emphasis added). Consultants were fearful that becoming involved in management would "compromise their clinical freedom" (Lee-Potter 1997) p.43). "I tell the [new nurse] managers that the first eighteen months in the job is the worst because they will all have terrible paranoid conflicts...The professional on one side of their head is saying different things to the businessman on the other side" (Strong and Robinson, 1990, p.73). "Doctors with a management role have the potential pressures that these possibly conflicting roles entail..How these individuals continue to cope with their dual roles will be critical" (Ashburner, 1996, p.222; cf. Hunter, 1992). Thus, efforts to incorporate this new management culture into the heart of the NHS met with considerable opposition from the medical profession.

However, the specific issue that caused the profession greatest concern was clinical autonomy. In Irvine's words "the contentious issue was the new accountability" (Irvine, 2001). At the level of the individual doctor-patient consultation:

moves to strengthen management [were] seen...as posing a threat to clinical freedom and as being antithetical to the

medical tradition of treating individual patients (Hunter 1992, p.558).

In response to a recommendation to the Dutch government that consultants in that country should be integrated into hospital management the BMJ reported that:

consultants have banded together out of fear that a so called "English situation" could arise...which they say will lead to a loss of professional autonomy and result in restricted access to specialist care (BMJ, 1996, 3 August).

But beyond individual clinical autonomy there was also concern about collective autonomy, overall professional control and power. A professor of health put it thus:

At the core of the debate about doctors as managers is the balance of power between the two groups...It would not be long before the medical profession suffered loss of status and control over the system (Hunter 1992, p.558, 259).

The increased threat to clinical autonomy arising from developments following the Reforms is graphically described in a BMJ article significantly sub-titled 'Sacred Cows: to the Abattoir'. The author, a specialist registrar, suggests that clinical autonomy has long been viewed by government as a threat to its control of the NHS. He presents, albeit in somewhat dramatic terms, a matter that clearly exercised him and many others in the profession. In an imaginary conversation between Aneurin Bevan and a Whitehall civil

servant the civil servant sets out a long-term strategy for removing clinical autonomy:

Firstly, you take the burden of administration from doctors by developing a complex management structure to run hospitals. Then, once the running of the hospital is out of their hands, rearrange things so that hospital administrators employ doctors”.

“I can understand doctors employing administrators,” said Bevan, “but not the other way around”.

“Of course not. It's ridiculous. So you dress it up. You point out that the new structure allows doctors no say in management. You suggest they become part of the administrative hierarchy to have a voice in decisions affecting clinical services... I think I can promise you that one day doctors will beg [the government] to take control (Orchard, 1998).

Griffiths, as already noted, was only the start of the reform process. With each change the medical profession saw more and more dangers to its professional independence and clinical freedom. And its immediate response was to oppose those changes. It believed and argued that what was damaging to the profession was ultimately damaging to patients. Thus, there was a moral obligation on the profession to oppose the reforms. In 1989 “the profession’s feelings...were beginning to consolidate toward the non-co-operation end of a spectrum of resistance”. A meeting of the BMA passed “a

motion put forward by a young surgeon that GPs should be asked not to volunteer for budgets and consultants asked not to take on management responsibilities” (Lee-Potter, 1997, p.92).

In due course, however, the profession with its eye on the “bigger picture” moved from opposition to working with the changes. Even a diminution of an aspect of clinical autonomy was accepted in order to protect what to the profession was the more important element of this key value. Klein describes the situation that developed:

The individual autonomy of NHS consultants does appear to be shrinking...Most notably, the post-1991 period has seen the mass production of guidelines and protocols which define good practice...The real significance of these developments is that the medical profession [is] acknowledging its responsibility...to give greater precision and visibility to the criteria against which the performance of individual practitioners can be assessed (Klein, 1995, p. 243).

He then points to the profession’s reason for allowing this change:

The medical profession appears to be ready to restrict the autonomy of individual clinicians in order to strengthen collective professional autonomy (Klein, 1995, p. 244).

In the context of this observation Irvine’s assessment of the medical profession pre-Thatcher Reforms is worthy of note. He described it as:

a medical profession that was too paternalistic and used to defining accountability on its own terms; consequent to that, a system of medical regulation [the core of professional autonomy] which was reactive, inward-looking, unresponsive and, as the profession and management wanted, concerned only with the most flagrant abuses or dysfunction (Irvine, 2001).

According to Irvine:

Mrs Thatcher, sensitive to changing public expectations, signalled that patients and the public had to come first (Irvine, 2001).

Thus, according to the retiring President of the GMC, the changes the reforms set in train, far from undermining patients' best interests had protected and enhanced them to the extent that an inward-looking and unresponsive medical profession had itself taken steps to change.

That was not how the profession originally saw or presented the reforms. And Hunter, summarising the result of his study of doctors as managers, indicates the nature and extent of the changes the profession was actually prepared to make. First he outlines the thinking behind the emphasis on management:

A desire to improve the quality of care and render services more responsive to user preferences has resulted in management being viewed as an effective means of tackling

these issues...There is a shift toward creating managers out of doctors with all that that implies...

But then he notes:

Far from managers incorporating doctors, the end result may prove to be the other way round...Medicine's traditional preoccupations and its resilience to change are likely to remain as strong as ever (Hunter, 1992, p. 557)

The medical profession's response to the management reforms followed a well-established path. Its "resilience to change" began with outright opposition presented as an ethical concern for patients' best interests, then an acceptance of the new situation followed by "tactics and practices" (Hunter, 1992, pp.563,564), designed to protect its "traditional preoccupations": those fundamental values arising from its ethos.

Which Values, Whose Ethics?

As the nature of the reforms became apparent, many experts, both from medicine and academia, offered their assessment of the likely impact. Paton, a professor of health policy, saw the whole move towards markets and competition as undermining the stability and popularity of the NHS. He characterised the response to these management reforms as supported on the one hand by government, health managers, and a particular group of academics but opposed by "most of the public; the vast majority of the medical profession; the majority of the nursing profession; and 'voices of conscience'... who

[see] the reforms as damaging the altruistic culture of the national health service *per se*" (Paton, 1996, p.344ff).

For Pollitt (1990, p.15), the reforms spelt a movement toward the imposition of "managerialism" - the system practised in big business and the military - on the welfare state. He noted the neo-Taylorian character of many of the changes introduced into the public services during the 1980s, in the bureaucratisation of the structures of control, as previously unmeasured aspects of the work process were measured and the information gathered was then used as a basis for controlling and rewarding effort.

Harrison *et al* (1992), pointed to the emphasis on proof of performance, explicit objective setting, and the generation of quantitative and/or dated targets, and termed the changes: "Managerialism on the Griffiths model". The approach, the authors contended, "is founded on distrust", whereas, "by contrast, consensus management and beyond that the whole diplomatic collaborative culture of the pre-Griffiths NHS is founded on trust" (p 68). The authors concluded that Griffiths' claim to be able to preserve the best features of the old consensus management system alongside the new management model, was open to doubt.

Metcalf and Richards (1993), offered a different perspective. They argued that NPM was more than merely "managerialism". In their view the term "managerialism" was a disparaging epithet employed by academic commentators with a deep-seated resistance

to management ideas. According to these supporters of the reforms, NPM involved not just a search for operational efficiency but also the promoting of effectiveness; in their view a much more difficult task. This, it was suggested (Ham and Hunter, 1988), could be achieved by raising professional standards through use of medical audit; standards and guidelines; involving doctors in management by delegating responsibility for a budget as well as appointing doctors as managers; and strengthening the external management control of doctors through contracts and closer supervision of medical work.

Wilkinson (1995) describes the values at the heart of NPM as representative of a “hate culture”, specifically referring to them as discriminatory, alienating, and dehumanising whereas “a British idealism for equity, compassion, and collective responsibility” are the fundamental values out of which the NHS arose.

Stewart and Walsh (1992) wrote of “conflicting interests and values” and noted that

many of the changes by the government can be seen as attempts to change the cultures of the public services, dominated as they have been by the traditions of administration, hierarchy, and professionalism...There has been...an emphasis on a commercial culture with a resulting search for an entrepreneurial approach. There are dangers if that emphasis leads to a neglect of the values of the public domain (p.150).

They concluded that “the management of public services has to be grounded in the purposes, conditions and tasks of public domain, lest it undermines the basis on which those services are provided” (pp.208-217).

Such views echo a widespread perception that the values of medicine are intrinsically moral with doctors generally trusted and respected. Managers, however, find themselves viewed in a very different light (Hunter, 1992, p.557). Thus, whilst one authority can refer to management as a significantly moral activity he also recognises that it is far from esteemed amongst the general population, with managers much more likely to be “ridiculed or vilified than praised and admired” (Pattison, 1997 pp.5,7). This is due, in part, to a cultural difference. Whereas in the USA, management is traditionally highly regarded with a well established and prestigious training programme. by comparison in the UK, management has been a rather impoverished concept (Metcalf & Richards, 1993, p 16). McIntyre (1994, p.73) presents managers as one of the central characters of what he sees as the present moral Dark Age who trade in “moral fictions” and embody “the doctrine that...all moral judgements are nothing but expressions of preference,...attitude or feeling”.

Although in the world of business and the private sector this attitude has changed, within the context of the NHS, management continues to be viewed with suspicion. In the popular culture, such

as television and radio dramas, the NHS manager is represented as “the villain” concerned only with saving, and even making, money whilst the doctor battles to save lives (Gabe & Bury, 1996, p.78). And a health service journal reports one prominent NHS user as speaking “warmly of dedicated clinicians” while expressing anger at hospitals being “run by accountants” with their concerns for budgets and the balance sheet (*HSJ*, 1997). The language of management, “management speak,” is dismissed as essentially trivial, furthermore, it “can be counterfactual, lacking in empirical basis, and downright misleading”. By contrast the languages of professionals are “tight, meaningful and precise” (Pattison, 1995, p. 542).

A junior doctor saw managers as:

act[ing] as if the NHS were their personal fiefdom...
provid[ing] themselves with expensive tools like computers
while clinicians are asked to make do with the barest
essentials...we know doctors diagnose and instigate treatment.
We know nurses...carry out treatment...We know
administrators ensure bills are paid, contracts honoured...No
one is quite sure what managers do. Their work appears to
deal primarily with the symbolic world of words and numbers
(Oni, 1997, p.20).

The assessment of another junior doctor was that:

Managers are not held in any esteem by us. We see them as
deriving largely from industry and commerce, looking for
secure sinecures on the NHS gravy train...Managers possess

no commitment to the NHS... [Their] agenda[s] seem so far removed from that of those with real patient contact (Gaba, 1996, p.33).

Against this background it is not surprising that doctors were apparently highly reluctant to enter the murky world of management as Dopson (1996), found in her small scale study of hospital consultants who had moved into management. Many of the consultants interviewed expressed their reluctance in terms of the “ethical dilemma taking on a management role created for them: alienating colleagues, undermining clinical relationships, and taking them away from patients and research that might benefit patient care” (p.183).

Management, Medicine, Myth, and Morality

In reality the relationship between medicine, management and morality is actually far more complicated than many of the rather simplistic comments noted in the previous paragraphs would indicate.

Indeed, Brereton and Temple (1999), suggest that NPM has exposed “the fragility of a myth of public service values that lie at the heart of British public administration”, namely, that public service is honest, impartial, passionate for justice, and not self-seeking whereas the private sector is “venal and profit-driven”.

Following the introduction of the NHS reforms of the early 1980s, Strong and Robinson undertook a number of studies on the

impact of these on the NHS professions. In their 1990 study they explored the attitudes and views of managers themselves, to the new managerialism. The study aimed, in their words, to “capture the vision that inspired most of the managers who were appointed in the wake of the Griffiths reforms” (p.65).

The new managers were “deeply committed to the new way of doing things” (p.65). They had been inspired by what they saw as new opportunities and determined to make the reforms succeed despite the many and obvious problems. Teamwork and good communication were identified as essential but also clear direction and control. “Let managers manage” became the new mantra. There had been great frustration at the old consensus model but alongside it was the awareness of the over-riding power of the doctor whose power had often worked against - in the view of managers - the best interests of patients. “Doctors were left to run things in the way they wanted and the power of medical syndicalism meant, so the managers argued, that a rampant individualism reigned throughout the length and breadth of the service” (p.32). An RGM told the researchers:

There was a study in our region of cataract surgery. The variation in length of in-patient stay for the operation was between three and twelve days with a mean of four days. Yet for the private patients the mean was just two days! When we challenged the twelve-days man he said it was to ensure high

quality of care - yet his private patients were only staying for two days (p.32).

Griffiths seemed to offer the chance to move away from these entrenched professional attitudes into a new direction. However, managers were angered at the doctors ignorance of management issues, their lack of interest in the new management proposals, and their refusal to play any part in the management side unless they were paid extra. This latter issue caused particular resentment among managers who were paid far less than the doctors. A DGM reported that:

Doctors in the acute unit think Griffiths is the worst thing that has ever happened to them because we have appointed a doctor as UGM and they can't understand how one of their own colleagues can be making decisions - particularly when it conflicts with the medical executive machinery (p.34)

Another manager described devices they had felt obliged to employ in their unit in order to avoid the necessity of paying consultants extra money for involvement in management decisions. "OK, it's a very small amount of money - but we feel very strongly about it".

Managers saw the individualistic ethics of the doctor as not only working against the best interests of patients but the NHS as a whole. "Some doctors were engaged in ruthless competition with one another for more power and resources...The clinical stress on

patients too often meant a partiality for the patients of the most powerful clinicians” (p.34).

A former anaesthetist assessed the doctors’ attitude as follows:

The only reason I’m treated with just a bit of respect in this district by the consultant is because I once was one...Doctors *as a group* are an absolute shower really. They’re worse than any other occupation in terms of selfishness (p.36, emphasis added).

Doctors were used to getting their way, often by bullying or patronising those whose role they saw purely in terms of responding to doctors needs. This assumption, based on traditional attitudes, carried through into their dealings with the new managers: “Many consultants...[assumed] that managers, no matter how senior, were there to serve them individually” (p.36).

Despite these negative images, the managers were also quick to point out that many individual doctors were “decent chaps”, “hard working”, “superb performers”. Significantly, from the perspective of this thesis, the criticisms were levelled against their character or “properties as members of the profession” (p.46).

Testing the Theory

The theory takes a nuanced approach by drawing out a subtle but significant factor that influences the medical profession, namely, the medical ethos. It explores the idea that the medical ethos, the

belief in itself as a noble and superior profession of special dignity and worth, informs the profession's responses and gives rise to an "implicit ethics of practice"; a mode of thinking and action that the profession recognises as right and proper from its members. The key values arising from this ethos are autonomy for the profession as a whole, clinical freedom for the individual practitioner, and paternalism. These are not merely traditional values, they carry the weight of moral imperatives. Historically they have been seen as right for the profession and this most senior profession's right (Morrell, 2001, Irvine, 2001).

Changes perceived as likely to impose any outside control, or even joint control, over its activities would undermine those essential freedoms and would be bad for the profession. Such changes must, therefore, in the first instance be opposed while in time "countervailing practices and tactics are developed that lessen or divert their impact" (Hunter, 1992. p.563). From outside the profession such an attitude might be dismissed as arrogant self-indulgence, but from under the umbrella of its own ethos the profession sees matters from a very different viewpoint. Even so, the profession also takes care to publicly stress the primacy it gives to patients best interests, a value emphasised in *Duties of a Doctor*, recognised in modern medical ethics, and more easily understood by those outside the profession.

This nuanced distinction contribute to our understanding of the medical profession's words and actions following the Griffiths and post-Griffiths reforms.

Management has always been important in the NHS. However, the particular form the management took was dependent on the circumstances prevailing at the time, and specifically what it was intended to achieve through that management (Harrison, 1988). Moreover, in the case of public sector management, the political order and the values informing its decisions also exerted a strong influence over the goals and, therefore, the structure of any management system (Ranson & Stewart, 1994, p.40ff).

Thus, during the first two decades of the post-war era values arising from a growing faith in the role of the professional with their expert knowledge, led to forms of management that gave to powerful professional groups a large measure of autonomy. Management was a rather low-key, back-room affair. In the health care context, managers were, in Harrison's words, "the diplomat[s]" (1988, p.31); "agents for physicians" (p.45); ensuring the smooth operation of the organisation in order to facilitate the work of the doctors. Under such an arrangement there was no need for management to emphasise any ethical credentials over and above those required to reassure the doctors for whom they were acting as facilitators. The doctors were content to work along with managers as long as they saw them as supportive and non-threatening:

At the level of practice within management, power is revealed in the capacity to determine the 'decisions' or the 'outcomes' within the organisation, a capacity grounded in differential access to resources such as information, finance or authority (Ranson & Stewart, 1994, p.43).

On this assessment, real power resided with the medical profession inasmuch as it was doctors who determined the decisions and outcomes within the NHS, whereas those ostensibly responsible for managing the system were merely administrators.

However, as government moved to a different "interpretative schema" - a new set of defining values that emphasised freedom, individualism, efficiency, and competition (Ranson & Stewart, 1994, pp.42,48) - questions began to be raised about the cost-effectiveness of medicine's contribution to the well-being of the nation. Thus, in the changing political environment of the late 1970s onwards there was a clear shift in the balance between the values of the medical profession and the specific values identified with management, particularly control of costs. The result was the political decision to bring medicine, and hence the medical profession, under firmer financial control. So the emphasis moved to the need for strong management.

This first element of the case study has demonstrated that the leadership of the medical profession saw a threat to professional autonomy and clinical freedom not only in the NHS reforms

themselves, but in the process that had produced the reforms. The Review had specifically excluded the medical profession, denying them the place they knew as their moral right: at the top policy-making table. This exclusion was perceived as a direct challenge to professional status; it undermined the authority of the profession and, thus had to be challenged. Exclusion at that level and around such a fundamental issue - the future of its NHS - was an affront to the profession's sense of self - the core of its ethos. The reforms themselves reinforced that perception.

This thesis argues that for the medical profession, the principles of professional autonomy and clinical freedom bear the weight of guiding beliefs; they are expressions of its ethos, its fundamental moral spirit. They cannot and must not be lightly put aside but rather must be fought for and defended. The leadership of the profession undertook that defence. And "high profile" doctors who appeared to support the reforms faced considerable pressure from their peers.

In presenting its opposition to the public, the profession always emphasised its primary concern as the best interests of its patients. The reforms were a threat to patients and that was why the profession had to take a stand against them. The theory of the role of ethos expounded in this thesis allows us to understand this manner of presenting its case as itself a product of the medical ethos. Paternalistic concern is a principle arising from and informed by it. What is right for the profession is right for its patients. Clinical

freedom and professional autonomy are exercised for the good of patients and anything that undermines those principles undermines patients.

NHS managers, however, operating from an alternative base saw matters rather differently. Outside the profession clinical freedom and professional autonomy translate into arrogance and obstructiveness (Morrell, 2001). Whatever the benefits they give to the profession, these are gained at considerable cost to the wider NHS, including patients. Hence, steps to constrain the power of the medical profession were welcomed and supported.

In due course the profession moved from outright opposition to accommodation and even, apparently, to a positive view of the reforms. Each position taken reflected the profession's concern to protect the core values that come from its ethos. "Doctors as managers becomes a stratagem for ensuring that no fundamental challenge is posed to their prevailing view of the world" (Hunter, 1992, p 565).

The above analysis has demonstrated that the concept of ethos can extend our understanding of the historical challenge presented by the management reforms, namely, how the leadership of the profession saw the challenge and why it responded as it did (Baeza *et al*, 1996 p.130). The next element of the case study moves on from secondary historical data to primary data made up of interviews with a number of individual GPs. This will show how the ethos

influenced the responses of practitioners in a branch of the profession situated at the lower echelons of the medical hierarchy.

Chapter 6

The Interview Data

The chapter begins by setting out some of the technical and other relevant details involved in gathering and handling the interview material. The body of the chapter contains the full text of one of the interviews. This, as noted earlier, is a guided narrative. Comments, observations and explanations are set within the body of the doctor's own narrative and lead in to a full analysis.

Recording the Interview Data

All but two of the 15 interviews were recorded on audio cassette; this was not an unproblematic procedure as on three occasions the equipment failed to operate properly resulting in material being either difficult to hear or lost completely. Of the interviews not recorded on cassette one was conducted over the telephone with the interviewer making notes as the conversation progressed and the other depended on brief notes made during interview supplemented by further notes made immediately following the interview.

The audio cassettes were all transcribed by a professional transcriber. However, no matter how competent the transcriber, this is by no means a straightforward procedure. On occasions, where the problems presented were of a technical nature, they were insoluble (Mishler, 1986, pp.47-49). Immediately after receiving each transcription I listened to the recorded interview alongside the

written text. Although this allowed me to correct major errors and "miss-hearings" there were still several occasions on which it was impossible to determine the exact word or words used, however in the context of the point being made I do not think any of these gaps have significantly altered the meaning. I was also anxious to include at least some of the "non-lexical expressions" as well as those interruptions, overlaps, hesitations, and pauses that the transcriber had left out but that I considered, again in the overall context, particularly significant. I realise, of course, that "particularly significant" is a judgement that I made and others listening to the same text may have come to different conclusions. However, it is precisely this process of refining and reassessing the spoken text that lies at the heart of transcription: "How we arrange and rearrange the text in light of our discoveries is the process of testing, clarifying and deepening understanding of what is happening in the discourse" (Mishler quoted by Riessman, 1993 p.60)

It is quite probable that were I to return to the material at some future date I would hear new things and change my opinion on some of the judgements made. There is no one "true" interpretation of the interview text for, as Riessman notes: "what may be the most persuasive interpretation of a narrative text at one historical moment may not be later. Our texts have unstable meanings" (Riessman, 1993, p.66). Equally at any one time alternative interpretations will be viable depending on the particular theoretical perspective from

within which the researcher undertakes the analysis (Mishler, 1986, pp.115-16). Finally, it should be noted that this approach is very time-consuming and so I made the decision to limit myself to no more than three playbacks.

Another decision I made was not to number, or assign made up names to, the quotes from the GPs as in my judgement this would not have added any useful information. This decision was, in part, forced on me by the particular circumstances of physically producing the thesis. I had set the data down without numbering the quotes. It was then suggested that numbering might be helpful so I returned to the data with that intention. However, my attempts to insert the information put a considerable strain on the equipment upon which I depend for writing the thesis and, thus, on my energies. The voice recognition system I have to use made it very difficult for me to add these small, but numerous bits of information. So tedious and time-consuming did the process become that eventually I decided it was simply not a practical proposition. This decision caused me considerable disquiet until on further reflection I saw that my approach was not uncommon and did not set any sort of precedent (cf. Strong and Robinson 1990, Allen, 1997). The text of one interview is set out in full and all the other interviews are given their setting to which I repeatedly refer when making direct quotes. This provided a degree of context sufficient to persuade me that un-

numbered quotes did not undermine the analysis or constitute, in any other way, a short-coming.

The interviews were, as I have already mentioned, of varied length ranging from 15 minutes to almost an hour and a half. Those interviews that provided more material are quoted most frequently but all interview data is referred to and quoted from in the text with one interview set out in full thereby allowing the reader to set direct quotes found later in the text in their context. Furthermore, the important distinction is between data from fundholders and that from non-fundholders. This is clearly set out.

I am confident that the material quoted and analysed in the following pages offers not only a fair and honourable representation of the views expressed by all those generous enough to be interviewed but also a valid interpretation of those views.

The Core Interview Data

Background

In 1991 the government introduced GP fundholding into the NHS. It was intended to give qualifying Practices, originally those with no less than 9000 patients, responsibility for their own budget. In 1992 the size limit was reset at 7000 patients and by the time of the sixth wave it had been reduced to 5000 patients. The first budget allocation was made up of five elements covering three areas of practice life: inpatient care for a limited range of surgical procedures;

all outpatient visits; outpatient diagnostic tests, excluding breast screening; prescriptions or the drugs budget; staff costs. There was an additional sum available for updating computer systems and management costs such as employing a Practice manager.

By 1993 the budget had been considerably extended. It now included chiropody; dietetics; community health services; district nursing and health visiting; referrals from district nurses, health visitors and community mental handicap nurses; community and outpatient mental health services; mental health counselling; services to those with learning disabilities.

Although called fundholders no Practice actually held any funds. Instead the relevant monies were held by the FHSAs and payments were made either directly by that body when authorised by the Practice or were set against the cash limit allocated to the Practice. However, any savings from one element of the overall budget could be transferred to another element

While the general practitioner branch of the profession fully backed and even, through its traditional representative the BMA, could be said to have taken the lead in opposition to the reforms, nevertheless a number of its members eventually decided to take the fundholding option.

April 1991 saw 306 general Practices take responsibility for their own budgets, they were the first-wave of fundholders. Each year after that a new wave of fundholding Practices came into being, thus

those who became fundholders in 1992 were "second-wave", those in 1993 "third-wave" and so on.

A pilot interview took place in August of 1996 with a GP who had, very reluctantly, joined a fundholding Practice just a few months earlier. The remaining interviews, forming the bulk of interview material, took place during the spring and summer of 1997, a crossover time between fifth and six wave fundholding Practices.

Selection of interviewees

The interviewees were self selecting: those interviewed had responded to a letter (see Appendix A) I had sent out to Practice managers asking if any of their GPs would be willing to assist in a research project looking into attitudes to fundholding. It is appropriate to note at this juncture that, on the advice of fellow researchers experienced in interviewing GPs and other clinicians, no direct mention was made of "ethics" in the introductory letter. A total of 84 such introductory letters were sent out to equal numbers of fundholding and non-fundholding Practices in one area of England. Most failed to reply, a few declined the request, and 15 agreed to be interviewed. Of those 15 the majority (11) were fundholders with only four non-fundholders responding positively to the letter.

I will not explore in depth the reason for this imbalance between the level of response from fund- and non-fundholders but in light of the controversy stirred up by the decision to become fundholders it

would seem reasonable to suggest that fundholders wanted to explain, perhaps even justify, their new position, whereas non-fundholders, having chosen to continue with the established way, saw no reason to make time to discuss the matter.

Although two of the fundholding interviewees were from first wave Practices by far the greatest number were from the third wave group. It has been observed that first wave fundholders as a group were generally more innovative and pioneering (O'Dowd, 1997), whereas those joining in the third wave were somewhat more cautious, less inclined to take risks. This generalisation perhaps fails to take account of the fact that the conditions Practices were required to meet before they could apply for fundholding status were changed between the first and third wave. Whereas prior to 1993 only those Practices with 9000 or more could apply after that year the figure was dropped to 5000. This meant that small Practices prohibited from joining at an earlier date were then eligible.

Interviewees

All but two of the interviewees were male; of the female respondents one came from a fundholding Practice and one from a non-fundholding Practice. Although none of the respondents were asked for their age it appeared that most were in their forties and fifties with one in the early thirties. The majority were English and all were white. The range of years in practice across both groups varied

from between 5 years, in the case of one fundholding GP, and 25 years for three of those interviewed. The rest clustered between 10-15 years.

The majority of doctors interviewed from fundholding Practices were “lead fundholders”, that is to say in their Practice they were the partner directly responsible for managing the Practice budget. The pilot fundholder interview was not with a lead fundholder, and the second non-lead fundholder came from a Practice where the lead fundholder was not willing to be interviewed. The GP who agreed to be interviewed had just completed an MA involving researcher-produced data and, knowing how difficult it was to obtain interviews, had taken pity on me and decided to be interviewed himself. The youngest lead fundholder interviewed had only been with the partnership for a few months and had been asked to take on the lead partner role by the senior partner. His own commitments prevented him undertaking lead fundholding responsibilities and it appeared that by appointing such a young lead fundholder he was in a position to maintain quite a considerable degree of influence and control behind the scenes.

None of the Practices served densely populated urban⁴³ areas although most of the areas covered have been undergoing relatively

⁴³ It has been suggested to me that doctors working in inner cities may well have expressed views rather different from my sample. Even if that were the case it would not alter the focus of my research which is the medical profession and its ethos. The interviews demonstrate the impact of that ethos on the thinking of a particular group of doctors at a particular time. While individual doctors will

rapid expansion; three Practices covered different parts of the population in the main town of a highly rural county, the rest covered medium-sized, but mainly small, towns and villages with their scattered outlying rural populations.

Thirteen of the Practices were multi-partnerships although none had more than 7 partners, the remainder were two partner Practices.

Location and length

Most of interviews took place in the surgery of the GP concerned, however two were conducted in small local, to the GP, hospitals and one over the telephone (this was a particularly difficult interview to conduct as the recording equipment was not suitable for use over telephone and I found some problems with taking notes). The majority of the interviews lasted from between 60 to 90 minutes while one was just 15 minutes.

The Core Interview

A number of factors influenced my decision to select the following as the core interview. The most important deciding factor was that the views expressed by this GP were absolutely typical of the views expressed by the majority of fundholding interviewees.

(Any significant divergence will be highlighted later in the analysis.)

respond differently to that ethos its influence within the profession and over the body of practitioners is the point at issue. Furthermore, reading the account of one GP based in an East End of London Practice shows that while he clearly eschewed many of the values I have identified with the medical ethos his form of practice, with its paternalistic view of his patients, was still very much in the tradition of the ethos (Widgery, 1992).

The interview is full and detailed both in terms of the ground covered and the depth of responses. There was also an absence of technical hitches in the taping and transcribing of the material. Finally, it is a good length. Not so short that little of substance emerges but not so long as to lose its focus.

This interview took place in May 1997 in the GP's consulting room. No written notes were taken during the interview but the whole 75 minutes was recorded on cassette. Transcribed material follows the numbering used in the original transcription.

Listening back over the tapes it is quite noticeable that whilst in the main the GP, who came across as quite an expansive, genial person, spoke very fluently with considerable self-assurance there were occasions when he took noticeably more time trying to find the right words, indeed he was at some pains to do so. At these points there would be a significant starting, stopping, pausing, hesitating and I have tried to show in the transcription these changes in his general manner of presentation.

Within the whole narrative account the GP introduces his own stories. In the majority of cases these are used to reinforce or justify his assessment of a particular situation. The one exception is in the telling of the story of how the Practice used its funds to empower "our girls", the nurses attached to the Practice.

The GP concerned had been in practice for 22 years, he was the lead fundholder. The Practice comprised five partners three of

whom had been together for a couple of decades with the remaining two partners having been with the partnership for nine years. The Practice was situated in the centre of the largest town in the county; a Practice had been on the site for several generations of patients and now the patient population of just under 9500 came from all over the town as even when patients moved away from the Practice catchment area they generally stayed on the books. The Practice became fundholding in 1991/92, hence it was first wave.

After gathering this background information I asked:⁴⁴

3) CD: What are your responsibilities in the Practice with regard to fundholding?

GP: Well I am the responsible partner.

CD: You are?

In discussing his role as lead fundholder the GP drew a distinction between the ideal method of operating and that which practicalities dictated as the modus operandi. In so doing, he introduced a theme that reappeared several times throughout the rest of the interview, and became a familiar topic in all the interviews, namely, tension. These tensions were not, however, linked in the main to specific ethical concerns. They were much

⁴⁴ Underlinings show speech overlaps.

more to do with the profession's ethos than principalist medical ethics.

GP: Yes. So I suppose I'm responsible..... Ideally I'm responsible for taking my partners ideas for how they want to see change forward and try to implement them. In practice, because since the new contracts general practice has become much more busy, I honestly believe a lot of my partners don't have enough time to think through the issues, uhm and therefore they tend to rely on me to have the ideas as well. Which is possibly a little unhealthy.

It would have been interesting to know what he meant by "a little unhealthy". I should have asked. However I didn't and as there was not an opportunity for second interview that question remained unasked. On this occasion, I believe it is not unreasonable to surmise that he is suggesting that possibly too much of the formulating of policy, as well as the carrying of policy through, resided in himself as lead fundholder rather than being a more group based decision. In fact, this seems to be the point he develops in response to my next question.

4) CD: So what dictates the approach?

GP: I mean it ought to be possible, if it's a priority, to make time. But inevitably whenever you do it's not other peoples' priorities. Other people, as long as they're getting the change they want, and you've got a general feeling for the way they want to move, they tend to let you get on with it. Though, of course, there's

always the danger that if you move too fast in the wrong way, too fast or the wrong way, then they'll ensure that your changes are sabotaged.

This response, and particularly "then they'll ensure that your changes are sabotaged", suggested a certain degree of tension in the partnership and I tried to explore this further.

5) CD: Does that create tensions in the Group as partners...

GP:... I'm aware of them, yes.

The tone of this comment conveys an unwillingness to discuss the matter further, my next remark was an attempt to try and encourage the development of the subject.

6) CD: Is that a difficult balancing act at times?

GP: We're very lucky in this partnership: three of the partners have been together for 22 years. The others have been in the partnership for 9 years. And I think if you're working with people you know that well, and we had a very big debate before we went into fundholding, you know where everybody's coming from. And so you, in a way, you're able to deliver what they want really without having to write off two or three afternoons to brainstorm it all and formalise it all and do what, in any reasonable management structure, is the way you'd normally go about it. But I think that if you've got Practices with a number of new partners then you've got to use the conventional management techniques and you've got to get everybody sitting down and deciding what they do want out of it.

The telling of this piece of narrative, the story of a happy, united Practice, in response to my suggestion that the position he had just outlined called for "a delicate balancing act", appears to be an attempt to on the part of the Doctor to move the discussion away from the issue of possible tensions. This may be because we are very early in the interview; as the interview progresses there are further opportunities to explore the nature of the tensions that he perceived arose from his position as a fundholding practitioner.

We now moved onto the question of why the Practice took the fundholding route?

GP: One of my partners was convinced that if we didn't (*speaking quite slowly with longish pauses*) we wouldn't get our share of the resources. That, looking to what was,... what the government of the time was doing in schools, uhm with respect to putting resources into "favoured" schools, if you like, that unless we got some control over the funds we were (*pause*) we were not going to be able to, you know, get the resources we wanted.

7) CD: Self-preservation?

This leads the GP to an assessment of the quality of management by the local health authority. He now narrates the story of a Health Authority merger to reinforce his assessment that they knew "nothing about primary care", were "pretty boring", "incapable of new ideas", "protecting their own backs", "not

considering the health care of the population at all". This judgement appeared to provide the main justification for the Practice deciding to become fundholders.

GP: I think it probably was, it probably was Initially, I think it was, yes. Uhm the bottom line (*pause*), yes it was a self preservation thing. The bottom line we asked ourselves..., I mean we had major problems with the health authority. You know, in those days the FHSA for [this county] was quite good. [County] health, there was an East [county] and a West [county]; East [county] health authority knew nothing about primary care and it really was a pretty(*8 second pause*) uhm, I shouldn't say conservative when we have a Conservative party but uhm, it was pretty boring, it wasn't... it was incapable of new ideas, right. Also the first thing they decide to do with the changes was to merge East and West health Authorities, so the result was that for the first year or two all the management of the health authority was protecting their own backs, uhm and not considering the health care of the [county] population at all. And it was quite obvious that this was going to happen, it was quite obvious that, speaking to the people who were supposed to be making the decisions, that they really knew nothing about delivering care on, you know, at the sort of GP hospital interface . Uhm and they were going to be totally preoccupied by protecting their jobs. And in fact..., so we thought well we'd better get on with it and do it ourselves. So I think there was an element of..., we thought, we

thought we could buy care better than the health authority could. And I think we were proved..., personally I think that in the first three or four years we were proved right. The health authority firstly had its merger, then it had a reorganisation where lots of jobs went; for, I think for three or four years, I really don't think they made any sensible management decisions because all the people in management were protecting their jobs and, you know, and worrying about reorganisation and whether they'd still have, you know, a job at the end of the year. And they just, I think they took their eye off the ball, bluntly. They were a shambles.

8) CD: You were keeping your eye on the ball?

GP: That's right. Absolutely.

I now wanted to try and clarify the thinking behind the decision.

9) CD: One tends to think that first-wave fundholders had an ideological motivation. . . . ?

GP: No that wasn't the case with our Practice, no. I mean, I do..., I think we were aware, and we're still aware, (*pausing*) that there are major stresses

(echoing "major problems" of earlier reply)

within the health service between uhm, free... a service which is free at the point of use and the fact that there is only a limited and finite resource. I mean, Enoch Powell said 30 odd years ago, that the

problem with the health service is that if you... if the cost is zero the demand is infinite, you know, in purely economic terms. So I think we were aware..., we were aware of that problem but I don't think we had any ideological commitment to the market to solve the problem. You know, you either need a better market or you need more central resources funnelled into it to solve its problems. And we didn't actually believe that the internal market was going to be..., the internal market was a bog-up, frankly, it's not a market at all. You know, it didn't..., it..., uh there was no..., the..., demand was not...,

(speaking slowly and thoughtfully)

demand was not controlled by any pressure on the patient to come up with something, was there? You know..., do-you-know-what-I-mean. So, so it wasn't a precise.... So there was no ideological aspect there. No.

The manner of these responses, the hesitations and careful searching for words, sometimes apparently unsuccessfully, ("You know..., do-you-know-what-I-mean. So, so it wasn't a precise...") indicated that there had been rather more reservations, even tensions, about the whole decision than perhaps he intended to suggest. I now tried to explore this further.

10) CD: Were there any qualms...

GP:... yes...

CD:... personal qualms for you?

GP: I wasn't the original partner who had the right id... the, the the idea to go in, but I was the sort of compromise candidate who was asked to look at it. And the more I looked at it the more I realised that health authorities were going to be a shambles and that... fundholding was really concerned with the manageable part of health care. You know, cold operations, out patients. And that if you actually ring-fenced that you could make major efficiency savings within it. I mean the situation pre-1990/91 where our local hospital closed for two months in the summer, because they'd run out of money because they'd been treating emergencies, meant they had millions of quid's worth of theatres lying idle, millions of, you know, not millions but a number of surgeons doing virtually nothing. Somebody suggested, one of the surgeons suggested, uhm rather than having a Works Department giving the anaesthetists paint brushes uh so they could do something useful! I mean the situ..., you know the whole thing ground to a halt. Now, you know, if you ring fenced the money for cold surgery, obviously you could then plan it, you could use those theatres effectively and you could bring unit costs down. Had to happen. So the more I looked at it the more I realised that if we had a ring fenced budget for those sort of, you know, those sort of procedures we could plan it, decide what our resources were, buy extra capacity on the margin at a cheaper rate,

bring our waiting lists down, and uhm deliver better health care for our patients, better secondary health care for our patients.

The story of the closed theatres is told to illustrate just how badly managed resources were under the old system. Fundholding allowed GPs to rectify some of these inefficiencies.

11) CD: You saw the positive side...

GP: ... the positive side of ring-fencing. But you didn't have to invent GP fundholding to ring-fence that funding. But nobody had thought of ring-fencing that funding before and as a result cold procedures were the poor relation of the health service and not getting a fair deal.

At first reading this full and very interesting response didn't seem to address the question asked. However, when I reread it several times more, I realised that the answer, and especially the narrative elements, offered quite an insight into the pressures that the whole fundholding debate had placed on the Practice. Thus, the GP describes himself as the "sort of compromise candidate" asked to examine the fundholding option for the group. Does this suggest that some partners were concerned that they might be bulldozed into fundholding by the partner who'd had the original idea, so there was need for a more neutral candidate to carefully examine the options? Twice he uses the phrase: "The more I looked at it the more I realised" suggesting that he was weighing up the arguments and gaining new insights. Then he offers two reasons

why he found fundholding an acceptable route for the Practice to take. One, "that health authorities were going to be a shambles" and two, that fundholding was a system for ring fencing what he calls "the manageable part of health care" cold operations, outpatients and alike, thereby allowing for more efficient use of resources and the delivery of better secondary health care. To illustrate the level of inefficiency under a non-ring fenced system, he offers the example of a local hospital that had to close its theatres for two months because they had run out of money for anything other than emergency work. Thus, he seems to be suggesting that, having looked at the whole question from a more neutral position than that taken by some of his partners, he had been persuaded that fundholding could be worthwhile. Nonetheless, it seems clear from his comment "but you didn't have to invent GP fundholding to ring fence that funding", that he still saw the fundholding option as a compromise, but one that was probably worth pursuing.

Perhaps though he was simply trying by this lengthy response, to gather his thoughts by directing the discussion away from a subject he did not want discuss any more directly. This occurs as a possible option when it is noted that, despite indicating some degree of reservation, the GP clearly says just a few moments latter (see below) "I personally had had no qualms at all".

Whatever the case, at the time I thought we hadn't looked in sufficient detail at the qualms partners may have had about

fundholding. Therefore I decided to try and take the matter a little further. I by began with a brief summary of what had just been said before coming back to the original question.

12) CD: So you saw a need to do something about the way resources were being used and then fundholding came in as the Government's answer, though not necessarily an ideal answer. Did you personally have any problems with the concept of fundholding?

GP: I personally had no qualms at all. Providing we were given a fair budget and not an excessive budget, because that would create other tensions, I had no qualms at all....

This matter of "a fair budget" will come up again when we discuss how the possibility of tensions created by an excessive budget became a reality.

.....Amongst the partners, I think we had three positive and two negative. One of the negative became positive, the other one was always a bit negative and at our final meeting we said: "look you've got the right to veto this; this is a big change, you don't, you know... if you really want to say no then say... veto". And he abstained. So we moved in on a sort of four out of five majority, if you like.

13) CD: And the sort of concerns expressed by others in the Practice were of what nature?

GP: Uhm, they were about... I think... gosh. I didn't express them so I can't really answer the question because your asking me to interpret other people's motives.

By this time I judged it was possible for me to press a question a little harder, but I didn't expect to be allowed to get away with pushing this particular line as far as I did. However, as it was central to the whole thrust of the interview I had to have a go.

14) CD: But you must have discussed them?

GP: Oh yes, but that's what people say is the matter. That's not what's really the matter.

15) CD: I see. So what was ostensibly presented as a problem?

GP: What was ostensibly presented as the matter was that uhm.... What was ostensibly presented as the matter was that it... that it involved money and that money was somehow alien to the health service culture. I mean, to which you could reply well call it resource points; we never see the money anyway, it's only a figure at the end of a... you know, call them Monopoly money, or multiply it by ten or divide it by ten, or whatever. But, ya, I mean, there was the, the, there was also I think, there was a huge amount of pressure from hospital consultants. Who were very much against it because they could see power shifting. And they, hospital consultants, have a lot of subliminal power over GPs. GPs sort of tug their forelocks, still, a lot, to consultants. And I think there was pressure brought, there were people feeling they were rocking the boat, they were, you

know, upsetting the established hierarchy of things and they didn't like... they felt uncomfortable with that. And I think that was actually the biggest reason.

Here was the first mention of the possibility of an ethical conflict, a partner expressing a moral concern about the fundholding route, but his colleague, who apparently had no such qualm ("I personally had no qualms at all"), was not prepared to accept that line of argument dismissing it as a mere subterfuge; the high moral ground covering over a rather less noble motives, namely a disinclination to upset the status quo, a bending weakly to the "subliminal power" of hospital consultants who saw fundholding as a threat to their power base. The moral concern was actually forelock tugging by a GP to a consultant. In other words, based more on values arising from the traditional ethos than modern principlalist medical ethics.

It is interesting that the expressed concerns, at least in this partnership, were focused around the issue of money. One partner had no qualms at all providing the Practice wasn't seen to be getting an unfair budget; the other partner felt uncomfortable with the whole concept because "it involved money and...money was somehow alien to the health service culture". Yet, whilst the first concern was presented as valid the latter was not. The thinking behind this assessment became, in my view, clearer as the interview progressed.

16) CD: From the point of view of your Practice here, what has been the most significant difference since becoming fundholding?

GP: The most significant? If you'd have asked me that two years ago I would have said to you: virtually abolishing our waiting list. Uhm, we had brought our waiting list down so that virtually no patient waited for more than (*long pause*) 5 to 6 months, and most of our patients were seen and treated within three months. Then we started to run into problems because there was a lot of... a lot of backlash. Uhm, actually also from some of the other fundholders.

CD: Really.

GP: Uhm, people assumed we had more money than anybody else. Actually we didn't; out of the 12 fundholders round here we're about the fourth lowest funded per capita. But then, uhm, [town] hospital had major problems with their theatres, they had to rebuild their theatres, there were long waiting lists, waiting lists went up because of that. We didn't feel that we wanted to move patients around horrendously, so we did actually allow waiting lists to move.

16a) CD: Rather than going out of [area]?

This comment refers to the fundholders option to contract with hospitals outside their immediate area for care of their patients.

GP: Rather than go out of [area]....

A positive aspect of fundholding, namely the ability to bring waiting lists down so that "most patients were seen and treated within three months" was abandoned apparently out of concern for

those same patients: “we didn’t feel we wanted to move patients around horrendously, so we did actually allow waiting lists to go up”. Yet, the next remark points to another motive.

....Uhm and that defused some of the political problems.

Earlier in our discussion this GP had castigated his colleague for presenting what was, in his judgement, nothing more than forelock tugging to the consultants, rather than a concern about undermining the ethical principle on which the NHS was based. To the outsider, however, the decision to “allow (an interesting use of the word linked to the increased power GPs were discovering they had) waiting lists to go up” seems to be as much, and perhaps even more about relieving some of the tensions building up between professional colleagues, “a lot of backlash” even from other fundholders, than about the good of the patients. But it is the ‘ethical principle’, patients best interests, that is presented as the primary motivation for the decision. The extent and nature of the tension is now described.

....I mean, some of my friends who are consultants were having some problems. You know, they’d say, well I’ve got to do this list for (names his Practice) because we’re bound on the contract. And within the hospital there were tensions about that: “why should we? Why should you do that? What about these patients?” “Well we’re not getting paid for those patients”. You-know-what-I-mean? “

We've got this contact with (names his Practice)...". It was creating some difficulties. Uhm, and as I say, uhm initially I thought that was the main thing, but actually it probably wasn't. Uhm, probably it wasn't because all we were doing was getting a short-term gain for our patients rather than really changing the system. Probably, in the medium term, I think in the medium term, the potential for what we can do in primary care maybe, may turn out to be the greatest change. Uhm, for instance, uhm, this building (*referring to the well equipped surgery complex. A large building that included a new minor surgery unit.*) I think probably cost 750K. Now there was absolutely no way we could have funded that through existing schemes. And we did actually only get 50Ks worth of savings from the fundholding. But that allowed us... all that 50K was spent on resources for health visitors, district nurses, and CPN service, and that sort of thing. So it wasn't actually spent on the GPs, it was spent on ancillary services

Another of the issues that created tensions between fund- and non-fundholders, was the fact that fundholders could keep back savings made from their budgets and, by such actions as increasing the value of their jointly held building, apparently profit personally from fundholding. Non-fundholders interviewed had talked angrily about this siphoning off of funds. Here the GP is at pains to emphasise that all savings were ploughed back into patient care, in this case by improving the range of ancillary services.

.... And we have excellent health visitors; they are running things like stress management clinics, childhood eczema clinics, enuresis (bed-wetting) clinics, they're doing a lot of things which within... And we've got an in-house CPN who's has his own office here and we work really close... he's in everyday; the management of psychotics is so much better when you're seeing people all the time. You know, I-I-I think actually being able to..., having the freedom to put a bit of extra money into... uhm resources in primary care...

16b) CD: mmm...

GP:...and allowing people to fulfil what they think they can do with their jobs, is probably going to be more important than just a temporary shortening of waiting-lists. Uhm, however we sat all the health visitors, and district nurses, and Practice nurses down, and we said: " Look, you know, okay, clean sheet of paper, what would you really like to be doing with their [sic] jobs?" And they were sort of gobsmacked, their managers had never asked them questions like that, you know. Up until then health visitors did nothing but sort of do developmental checks on nought to fives

CD: nought to five's, yes...

GP: d' you know what I mean! Uhm so the idea of actually being empowered to do... and we're going to take... we... I'm now chairman of a multi-fund of fundholders and that's an idea I want to take forward in the autumn across the ten Practices in the multi-fund, you know. And looking to use health visitors, you know, minor

illness clinics, uhm all sorts of... which would help with the load on GPs, *but* also developing their own skills and possibly, you know, swapping, cross Practice transfers so that, you know, our girl will be the, if you like, the enuresis specialist and she might help enuresis management across three or four Practices, some other health visitor might do something else. You know, I think it's the, the ability to affect change within primary care.

17) CD You've got flexibility.

GP: Exact... and that is where I think the real benefits are going to come from, you know, but that's taking a long time because changing attitudes and-and, bluntly, having the guts to do it, ah has been, you know, that's-that's come later I think.

18) CD: Ya, ya, because initially you saw it in terms of, as you say, shortening waiting lists?

GP: Ya, I just saw it as a sort of mechanistic exercise, you know, we could uhm, uhm... purely economic terms, you know, uhm, you know, buy this amount of operations if we make...; in the early days it was quite easy to make savings on drug budgets because drug budgets were relatively generous now their absolutely horrendously tight, that's a major problem; but if you could make a £30000 saving on a £1/2 million drug budget you had £30000 to go back to the hospital with. Now you go back to the hospital with £30000 and do a marginal cost deal on another 70 patients and

you've only got 140 on your waiting list, it tumbles pretty damn quick, you see.

CD: Yes, yes.

GP: Uhm, so it was possible, as I say. But again, but that, as I say, created tensions, it created tensions within the hospital which were unhealthy; it created tensions within the medical community which was unhealthy. Unless other people got their act together; and I kept saying to people: "look why don't you do the same?" But they didn't have quite the control over their drug budgets, or they couldn't... they didn't seem to get their act together. So it didn't happen.

Once again we returned to the theme of tensions around the budget and savings, this seems to have been the issue that set fundholders apart from the rest of "the medical community", and roused the greatest general hostility toward fundholders. It appears that much of the time was spent working out a compromise position in order to facilitate a reasonable working relationship within their home district.

19) CD: Getting control over drug budgets. How have partners responded?

GP: I think...to be honest, in the early days, you know, uhm, a lot of GPs were using a lot of expensive antibiotics because that's what the drug reps were coming round saying, now all the evidence is that for 95% of conditions in general practice the older fashioned,

cheaper, generic products get just as good results and you can, you know, save a lot of money by using them. If you then use those products that are just as effective, the patients aren't suffering, uhm and your freeing up money for other things. I think things have become so tight now that actually (longish pause) you could almost say that GPs in general are not spending enough money on some drugs. You know, in some areas.

CD: Because of the financial pressures?

GP: Because of the financial pressure, ya. Ya, I think it's, it's going to be.... I mean, whether..., because we've had good financial controls in this Practice, it hasn't hit us - yet, I think it might do this current year, uhm, for the first time in seven years. But what I said to my partners when we embarked on it, I said: "look, I think we've got five years on this, after that everything's going to tighten up and it's time to drop it". So we've had two more years than we expected.

This assessment, offered apparently at the outset of the project, indicated that the Practice did not see fundholding as a long-term option, but as a short to medium term opportunity to change the boundaries in favour of primary care. Fundholding presented a business opportunity for those whose business was health care. The considerations of modern medical ethics did not appear to figure prominently in this equation. However, it was thought important to keep the pressure off the sensitive areas.

21) CD: Mmm. When you say drop it.....?

GP: Well, bluntly, bluntly, if this government decides it wants to do away with fundholding it doesn't have to pass an Act of Parliament, it just tells health authorities to knock everybody's budgets by 10%, doesn't it, you know? The whole thing becomes unviable, and if that happens you've got to walk away from it.

22) CD: It may be forced upon you?

GP: Ya.

23) CD You talked earlier about multi-funds and that seems to be one of the alternatives that is being suggested now.

GP: That's why we formed a multi-fund, yes.

CD: Right?

GP: Ya.

24) CD: Again, seeing the direction things are going in the future?

GP: Well, trying to. But it's a bit bloody difficult, isn't it, with this government? I mean, you know, I've got nothing against them, uhm, but it's actually quite difficult, it was incredibly..., one thing they would not do in their manifesto or pre-election, was tie themselves down to what they *were* going to do, in terms of the detail we want to see where we're going in the health service. So, I mean, I think we live in a very uncertain time, we don't know.

25) CD: Has that been a problem? You're not clear exactly where it's going?

GP: I mean, I mean, it's been an advantage, hasn't it? It's been a huge advantage in the past because fundholding was *the*, you know, *the* blue-eyed baby of the Conservative government, purely by accident, but it was. So, you know, you could always pick up the phone to Region and have a bit of a moan at them and things got sorted out. Uhm, this last year things have changed, the Region has read the tea-leaves, you know, their not going to be quite so close to fundholders as they were.

CD: Oh right.

GP: But the political situation has been one that has been very useful to exploit when health authorities have been a bit slow to move.

26) CD: Ya, so it sounds as if, as you say, for the first five years, and possibly seven, it has been a reasonably friendly wicket to bat on?

GP: Yes, yes. If you managed things well.

27) CD: By the lead fundholder?

GP: Yes, and he's got to have good information, so the financial information that's coming through's got to be good.

28) CD: Has fundholding changed the way you see and approach decisions as a GP?

GP: I suppose it must do. I think one is (longish pause), one is probably more aware of the cost-benefits, and one queries (pause) much more (pause) whether it's worth using the secondary sector in

certain areas where you know very well, 20 odd years of experience has told you, they don't deliver much and they are going to turn you out a bill for two or three thousand pounds for it, do you know what I mean? So, I think ya, I think you become..., I think you must..., you must become much more cost aware. Uhm, now whether that's a..., in conventional medicine that's a bad thing (long pause) but I think it's something we've got to get to grips with anyway.

29) CD: When you say that in conventional medicine that's a bad thing what do you mean?

GP: ...ya, ya I mean the doctor's is supposed to be there tooo (pause) tooo be the patient's advocate and get the best (pause), the best he can for that patient. And he's beginning to have to view things in terms of (pause) the good of the community rather than the good of the patient. And there are, obviously, increasing conflicts there, you know.

Here we had an issue that appears to have caused the GP considerable problems, words such as "increasing conflict", "constant dilemma" "tension" are used. To illustrate the nature of the dilemma, and to emphasise the cost to the NHS of the traditional role of the doctor as patient's advocate, at this point he wanted to introduce a particular example, but aware of my wheelchair he didn't want to cause distress so first he had to clear the way for what he wished to say.

30) I mean, uhm, with respect, I don't know what your condition is uhm.

(I very briefly named my 'condition'.)

GP: Okay Well let's take something like MS. That's why I didn't want to put my foot in it. Uhm, you know, you've got these new drugs coming in, say, right? Now, as a GP one would say to your patient: "Well look, let's at least give it a go". And yet the evidence is that very, very few people are going to benefit and, then, only very much on the margin and maybe for only six months or a year and then, at the end of that time, they're going to be back to square one. So, the health economist would say, this isn't an effective intervention. 10000 quid's worth of drugs for the year, you know, we could get 20 cataracts done for that price. At the end of the year the patient's going to be back at square one, all we've done is loosen them up a bit. For the patient it's very important to be loosened up, day's.... that..., d'you see what I mean?

CD: Ya, ya.

GP: So, you've got this constant dilemma, haven't you? Between the individual, who, obviously, wants the latest thing, at least to try. If you're terminally ill your going to clutch at all straws.

CD: Right..

GP: And yet, statistically, that straw may be a busted flush. I mean on the... you know, there's a hyperbaric oxygen machine in the (home for care of MS patients) in a..., out in (nearby large village)

which was going to be *the* answer to MS 20 years ago, you know. The population raised, the population of [town] raised, £200,000, when that was quite a lot of money, to get that machine. They were totally useless; but we had to have it because the demand for it was there. That's, that's the tension.

31) CD: Extrapolating from that a little bit. Is there a tension as you as a fundholder think about your little area, your patient population, against the wider locality and you say my patients first?

GP: There those are the sort of conflicts.

32) CD: Is that a particular problem with fundholding?

GP: I think if you've got patients waiting for cataract operations, I don't have any particular problems. Because, to my mind, 20 cataracts is worth more than 10000 quids worth of non-effective health care. Now, trying to explain that to that one patient may be a problem, uhm, and that's where, you know, I think the government's been deliberately naughty in..., in saying all these decisions must be made locally, you know, at health authority level or even at Practice level. I mean, it would be much easier if centrally a decision was made that this was not an effective mechanism and, therefore, it would not be part of, uhm, NHS treatment. Now those decisions are now being made by health authorities, 'cos somebody's got to make them. The trouble is you get different health authorities making different decisions, different things. So you find Mrs X, one side of the border, can get a treatment and Mrs Y can't. I don't

know whether you read that down in Bristol, some sort of breast cancer treatment.

CD: Yes.

GP: Uhm, so. The government's made damn sure that they haven't...

CD: ... the buck doesn't stop....

GP: ... stop with them, yes. Uhm which is a shame because, bluntly, it's much easier to say to people: "look, I'm sorry, this isn't available on the health service" full stop (longish pause) than it is to, you know. If people say: "you're a fundholder, you've got the money" then you've got to say: "well, I'm sorry, you know, even though we're fundholders we're not prepared to fund procedures that are not available for non-fundholders". You know, you have to use various strategies to get around that I think.

Here the GP seemed to be saying that decisions regarding what treatments can and cannot be offered to patients ought to be made centrally and applied nationally. But as we developed this theme he also made the point that he wanted less centralised control, more freedom to run his show as he saw fit. Furthermore, he argued strongly for doctors accepting responsibility for their spending, taking much more account of costs against benefits when making treatment decisions.

This somewhat contradictory set of arguments well illustrated the challenge that fundholding presented to conventional medical

thinking. Here was a doctor prepared, as a fundholder, to accept what doctors by tradition had seen as beyond their area of concern, namely, the cost implications of their treatment decisions. The profession had up to now regarded that either as a matter for the patient themselves, or some third party mainly over recent decades the state-funded NHS. And yet this GP was still clearly uncomfortable with the full implications of stepping outside the traditional medical position; he still wanted someone else to take some of the responsibility for making the difficult treatment allocation decisions a limited budget made unavoidable.

These points are developed following my second attempt to raise the issue of fundholding Practices having a ring fenced budget, a point made forcefully by the non-fundholders I'd interviewed

33) CD: Oh right. Yes, but then in terms of fundholding. Your concern is with your patients. in a sense. your budget is ring-fenced for [your Practice]. Now, if, as you mentioned earlier, you save, say. £10,000 on your drug budget then you can use that money within your Practice for what you want to do. Whereas under the old arrangement, if that money was saved, it would go into a larger pot and maybe benefit a broader spectrum, or a particular group who were, at the wider level, in difficulties that maybe were not necessarily reflected in your Practice. Does that present some problems to you?

The response identified the problem that arose when people made arms length spending decisions. That is to say, when they were not directly affected by the consequences of those decisions.

GP: I think there's a dan..., I mean I think if-if-if the benefits of the savings are too far removed from the people making the savings, then there's no incentive to make the savings. So you're not going to get them anyway. Right?

CD Ya.

GP: Now, I mean its, it's an interesting issue and it's one that, I hope, we've resolved within the multi-month. What we've done in the multi-fund is restricted the amount of savings that any Practice can keep for themselves to, say, £10-£15000. And all the rest will go into the multi-fund (pause) savings for multi-fund development. So that the Practices will still get a benefit 'cos they'll share in those developments.

34) CD: So there is still an incentive.

GP: So..., there has to be yeah. And now, it might well be that, as the multi-fund develops, and savings get less and we can show that the multi-fund centrally can give benefits to the individual Practices, that we can do away with the concept of being able to spend savings locally. But we have to keep the incentive there.

35) CD: Yes. So it was a problem that you recognised and had to deal with?

GP: Oh yes. That's right.

But the incentive to make savings raises its own problems and it is to this that I now turned.

36) CD: Thinking about savings? Is there ever a temptation to provide “in-house” more cheaply than which might be ‘better’, from the patient’s point of view, provided outside? I notice, for example, that you have a minor surgery unit here. I’m sure that that is a thoroughly good thing but is there a potential problem?

GP: Yes, of course there is. But actually I, I mean I don’t think there is a dilemma here. Uhm, I mean if you look at the audit of our results for the minor surgery unit everybody’s really happy with it, all the consumers. Uhm, I presented the audit to a medical meeting of GPs, consultants, and so on, you know, and one of the consultant surgeons said: “Well, you know, it’s a one stop service”. You know, you come in, you’ve got something, you’ve got a lipoma, or even a vasectomy, you come in, you chat with the surgeon, you’re through in the theatre, you have it done. It’s one stop. you know. And he said, you know. “I really don’t know why we haven’t been doing that for the last 20 years. Patients are always saying to me ‘well why aren’t you going to do the operation doc?’ And I say well no I’ve got to put you on a waiting list, it’s going to be six months time”. Again, you’re changing the pattern of health care for the better. Uhm, I think people actually like to have facilities and resources locally. Uhm, and I think that, unless you want instant access to high-tech equipment, at least half the stuff that’s done in hospitals

could be done in the community. And I think it could be done cheaper.

The problem was accepted in theory, but in practice, as the story he narrated was meant to clearly show, it really didn't exist. The real difficulties arose from the status quo encouraging a profligate hospital based system, rather than from fundholders too concerned with cost-cutting.

37) CD: Do you mean more effectively?

GP: More effectively for the patient. Uhm, so, I don't think we've started, we haven't scratched at the surface yet of what we could... The snag is that hospitals require such huge amounts of money to keep running that the whole system is, you know, if you try to move too much away the price for everything else goes shooting up and-and.....because they can't seem to be able to down-size.

CD: It's rather like the mighty liner trying to turn.

GP: That's right, yeah Absolutely

38) CD: Thinking about the facilities you have here, which look absolutely amazing. The patients next door, so as to speak, don't have those facilities because that is not a fundholder. Some talk about a two-tier system. Is there a dilemma?

Once again, the GP acknowledged the possibility of a problem, even an ethical dilemma, but immediately exonerated his own practice and Practice with a lengthy narrative account.

GP: Yes, yes *if* that's what we were doing. We embarked on that project (long pause) because we believed in it and because we had outline agreement with the clinical directors of (local) hospital that they would use it. That they would shift suitable cases down there, free up capacity, uhm, at uhm, in the day case unit, free up capacity in the main op... you know, get a cascade affect which would have increased their efficiency hugely. And the idea was that..., it's not for our patients, okay. In fact, only the gynaecologist carried on with that scheme. The others, their morale got so low and they were fed up with all the work they were doing and they just said no they were too busy, they couldn't possibly come and work outside the hospital. So they all backed off, so we had to find other people to come in. So the gynaecology service we run down there, the hysteroscopy service, isn't anything to do with..., isn't two-tier in any way. It's run for the patients in (the whole area) Right? The minor surgery service we run down there, and the cataract service we run down there, at the moment is only available to fundholding patients, but *all the fundholding patients*. Right? And we've said to the health authority they're very happy to use it. We can provide, we can provide simple procedures at half the price of (the local)hospital. We can provide cataract at a little bit cheaper, maybe 10% cheaper. But the health authority is so wrapped up with big hospital expenditure that it simply hasn't been able to withdraw funds out of the hospitals without... The hospitals are already running at £2 to £3

million deficits, so anything they move out of the hospital makes the hospital situation worse. So they're locked in, right. Now, I mean, that's all wrong. They're paying far more than they need to for a certain percentage of their procedures, but there's nothing... We're not, we're not running that service just for us, we're running that service for whoever wants to use it. If the people..., if the non-fundholder... if people purchasing for the non fundholders don't get their act together and want to use it well then that's-that's that's not our responsibility. But I don't have a problem with a two-tier system because it's there on offer.

39) CD: And on other levels, do you feel that the concerns about a "two-tier" system have any validity?

GP: No!

The vigorous way the GP responded to my question suggested that he and his fellow fundholders had had to deal with the two tier issue, and all the objections and counter-arguments, on many occasions. It was clearly a topic that had raised strong feelings on both sides, but the fundholders were not prepared to concede that their position disadvantaged the patients of non-fundholding Practices.

Although the "no" is clear and definite the rest of the answer recognised that a two-tier system was operating, but it was not always in favour of fundholders and when fundholders appeared to be gaining some advantage this was merely a temporary measure

whilst they undertook the role of guinea pigs on behalf of their non-fundholding colleagues as the story of the back clinic demonstrates

.....If you're going to affect change, you're going to create a different system with different standards right? By definition that's two-tier. Now, our first attempt at purchasing physiotherapy in the community was a disaster. Uhm, there were huge waiting lists, the woman who was supposed to be running it kept losing the the appointment books. Uhm, there was a two-tier system and our patients were getting the worst system. (General laughter) Right? No problem. You know. Of course there was a two-tier system and that's one that, you know, fouled up. Right? We run a back clinic, okay. We uhm... There's about a years waiting list for people with back problems; we've got a GP who comes in, he assesses everybody, he, uhm, works up those who might need surgical intervention from a consultant who comes in just once a month. So, uhm we've brought waiting times down to that clinic down to 6 to 8 weeks; classic two-tier system, big row with the non-fundholders, you know. Uhm, we said: "okay, well look why don't you just send a few patients down if there urgent. You know, we'll... we've got a bit of capacity we'll see some of your patients". "Ooh, mustn't have our patients sent their, two-tier system, it's all in the community, must be in the hospital. Terrible". Right. We now have a commissioning group, which is two fundholding GPs, three non-fundholding GPs. The first success of that commission group is

getting that back clinic available for everybody. Okay. I see what we did there not as a two-tier system but as a pilot scheme which we showed worked, which is now being rolled out for the benefit of everybody in (the area) But if you establish a pilot scheme and it works, obviously, those who are benefiting from the pilot scheme are getting a better deal, otherwise if their not, it's not working and there's no point in pursuing it. If you're going to be successful you have to create a two-tier system. The important thing is that that should be a temporary two-tier system and that the structures should be in place to take those good ideas forward and ensure that the playing field is levelled out. And the most vociferous opponents of that back clinic are now it's biggest supporters.

40) CD: Mmm. That's an interesting point about the structures being in place to level out the playing field. Do you think that, in general, those structures are in place?

GP: They are now in place in (this area) through this commissioning group. They're not in place, as I understand it, in (the neighbouring area) where there isn't really a strong enough commissioning group or in (names another neighbouring authority). I think that's fair. I think we've got an extremely good commissioning group which started off with a lot of... certainly a lot of anxiety on my behalf in that this was just going to be a committee that tied our hands behind our backs. I'm glad to say it hasn't and I think there has been a lot of mutual respect between a fundholders

and the non-fundholders. And it's going to be a very powerful force. And if we've read the tea leaves correctly it will be the right way forward.

41) CD: Are there constraints operating in the fundholding system?

The reply highlights the extent of the ill-feeling between fund- and non-fundholders even 5 years into the scheme. The problem still presented in terms of the shift in power that fundholding created. However, it also revealed that fundholders had taken matters rather too far in some cases, resulting in central government curbing some of the new found freedom and restoring a degree of control to the local health authority. The GP rails against this stifling bureaucracy.

GP: Yes, the health service is still totally bureaucratic and there are a lot of people who very much resent the power shift to fundholding. And they're all going to come roaring out of the woodwork now. It's going to be great fun: all the people who have been paying lip-service but actually not really very much in favour, in health authorities and in Trusts, are all going to come pouring out of the woodwork to stab the fundholders in the back now.

Vivid imagery that powerfully illustrates the strength of the ill-feeling that still existed five years into fundholding. Once more the doctor uses a narrative account to reinforce the point.

And, you know, it's little things, you know, provider numbers for instance. You know, the regulations are intensely complicated if we want to provide services. A GP wants to provide services in his own surgery, theoretically he can get a provider number now and get approval, okay. But the trouble is that nobody ever thought of the fact that GPs are actually too busy, we can't all be dermatologists as well, or, you know, surgeons as well, or do these other things. So the obvious way to handle it is to bring in, into primary care, people with skills. Married women who are doing three or four sessions a week at the ophthalmology department who can handle our ophthalmology in-house at a level in between highly specialised consultant and general practice, for instance. Now, the provider number business doesn't allow us to do that, 'cos you have to be a principal in general practice to have that sort of provider number. And I've spent four or five months trying to organise a provider number for the building, so that the building can become a provider, and then we would submit each individual who comes to work here, their CVs, to make sure they're up to quality, I don't mind the health authority, you know, monitoring quality in that way. But the system doesn't exist to do it. So the Director of primary care has been, you know, on the phone to Region trying to get decisions out of them. He's finally phoned me last week and said: "Look, sod it, let's just go ahead with it and I'll find you a provider number". But I mean, that sort of bureaucracy is still in there, you see. You... you know,

there's still... I think the first year of fundholding things were far...got so loose, with people forming these companies and so on, the government just took fright and the bureaucracy took fright and wanted to grab control again. So there's still far too much control in the system to really innovate

In response to a government ruling that fundholders could not provide services in-house but where to remain purely as purchasers, some Practices had opted to form private companies, enabling them, so they argued, to operate as separate providers. After initially allowing this practice, the DoH changed its mind and forbade any further such activities. It did agree, however, to allow fundholders to undertake a very limited range of procedures for which the partners would receive payment from the fund. But even this concession was hemmed about with many restrictions. The entrepreneurial fundholding GPs found "these intensely complicated regulations", and the "totally bureaucratic" attitude that underpinned them extremely frustrating

42) CD: You talked about the power shift as consultants have had to recognise that their GP colleagues have some status and power of their own. What about the relationship between colleagues?

GP: Oh yeah (laughs). There are certain consultants in the hospital who are just a disaster from that point of view and are constantly trying, you know. I mean, there's one, you know, I mean, you know there's one who has managed to block virtually any

ophthalmology development that we wanted to do here, which we've been trying to do for a year to eighteen months, with the result that we've got IOS, independent ophthalmology service, people doing cataracts. That shouldn't have happened, it needn't have happened, you know. I didn't necessarily want them in here but I was going to make damn sure that *those* people didn't control what I did in my building, you know. (Long silence)

43) CD: Has this affected the collegiate nature of the medical profession?

GP: Well I think it's a bloody good thing, frankly, because the people who are objecting to change we can't afford them anyway. They've got to be shaken out. But then, perhaps I'm a bit radical in that respect; I don't think all my colleagues would agree. I don't think we've gone far enough in that; I don't think we have brought home the lessons of responsibility for costs. Again, it's this dilemma, isn't it? I think nowadays all G . all doctors have to accept some sort of responsibility. They either have to live within a health service which has a finite budget, in which case they have to accept responsibility for the costs they're generating, and whether they're effective or not, or, if they wish to be the patients..., I know this sounds crazy, I know..., but if they wish to be the patient's advocate and give the patient everything the patient needs, they have to be in the private sector because that's the only place where their decisions aren't going to impact on the rest of the population. Ya? Now

the..., I mean, the fascinating thing is that the people who are (pause) the strongest patients advocates are also the left-wingers who are very keen on the concept of the health service. And they... they... they've got a ..., I mean li... it-it it's just not a logical... and that... one of the advantages of having a Labour government is perhaps that will come home to the left-wing of the profession. You know, that you can't have, uhm,... and it's nothing to do with fundholding, I mean it wouldn't have mattered, whatever health care system you've got in the world you've got this problem, haven't you? I've worked in America, many, many years ago, and saw the difference between the poor and the rich 'cos I was in the pathology department, uhm, doing the post-mortems, you know, uhm. So, (*struggling to find the words*) you've... when th-th-the people who... th-the people who are objecting to the sort of things that we're doing are the sort of people who want the autonomy to be able to continue to practice in the way they think is best for each individual patient. Now, I respect that. What I don't respect is the idea that they can do it within the health service and gobble up a higher share of the resources than they need to be doing. Because in doing so, they're disadvantaging other people. I don't mind if they do it in the private sector.

45) CD: Has that had an effect on clinical autonomy?

GP: Oh yes, but I think that had to come anyway. I mean, and I think you'll find, fascinatingly you know, when we have our consortium meetings now, which is fundholders and non-

fundholders, big consortium with a representative from each Practice, there is a... there is a view right across the medical profession, not just in fundholding but amongst the non-fundholders as well, that they can't have their cake and eat it, that the health authority has finite funds and that we have to look at priorities. And there is just as much enthusiasm for saying the health authority is wasting money here, you know, we shouldn't be doing this, as there is for saying this is what we want more of. So I think the shift isn't, you know,... maybe fundholding focused it, the market focused it, but it-it had to happen.

I was now aware that we had been talking for an hour and I couldn't take much more of the GP's time.

46) CD: Can I just conclude by asking about the management values that you've had to bring into your Practice. Do they sit well alongside your professional values?

GP: Yes. I feel perfectly comfortable with it and I think what fundholding has taught me is that good management is good management. And, hopefully, that reflects in the way the whole Practice is run: the way patients get appointments, the way we handle, uhm, urgent appointment as against routine appointments, the way we deal with people on the phone, you know. I-I would hope..., I would think that there is a... there's been a beneficial fall-out, our exposure to modern management techniques has had a

knock-on effect, not just in managing the fund but throughout general medical services.

47) CD: Some might think that is has been purely cosmetic, the “have a nice day” approach, but

GP: ... I would hate to think it had, I would hate to think it had. It’s not a phrase I ever use (general laughter) but I know exactly what you mean and perhaps... It’s difficult isn’t it, to find a... I mean, what do you... what do you want when you go into a doctor’s consulting room, you know? You don’t want a meaningless “have a nice day” but you do want, I suspect, some sort of body language and words which do convey an interest in you as a person.

48) CD: Does thinking in terms of management values make that more likely to be achieved?

GP: I would hope so but I haven’t got any evidence for it.

49) CD: Do you get some feedback from your patients about how it’s all working out?

GP: We’ve been very, very reticent about adverti... because of the political sensibility, we’ve been very, very reticent about advertising the fact we’re a fundholding Practice.

50) CD: Do patients notice?

GP: I think they probably do. But actually our patients have been very good; very, very few of them have pushed it. Very few of them, I’ve had one or two people who’ve written me letters saying: “since you’re a fundholding Practice, surely you can get me my

operation done down at such and such a hospital next week, rather than waiting for three months in (local hospital)". That's happened a bit but not-not-, it's not been a big issue.

Patients were not fully informed about the fundholding status of their GP Practice because the doctors concerned feared that such information might result in large numbers of patients 'pushing it' and demanding particular or preferential treatment. However, the fear was not realised, most patients "have been very good". This decision is fully in line with the ethos of medicine, where the traditional view taken by doctors with respect to giving their patients information seems to be a paternalistic least said the better.

51 CD: Do you feel, by and large, that the two sets of values can sit alongside each other?

GP: (longish pause) A publicly funded health care system, because it's so short of money, has to be, to my mind, managed in a first-class way. And I think one of the problems the current government is going to get into is that if it thinks it can cut management (pause) much more, in order to shift that money into patient care, it's going to find that it's going to go back into a badly managed system, where it doesn't know what it's doing and it's doing all the wrong things. I think that's the big trap it's going to fall into.

52 CD: But you see the future of health care provision in the community in term of the consortium?

GP: Hmm The consortium? Yes, yes (*Fidgets around on swivel chair, its squeaking can be plainly heard as he now speaks*)

The consortium's going to have its own tensions; the consortium's going to have tensions between the Practices that were comparatively well funded and the Practices that were comparatively badly funded. Those tensions aren't too much of a problem because it was obviously inherently unfair that X got £150 a patient and Y got 84. Right. That's greater than the difference you might expect by different list sizes and (indecipherable) populations. Where the tensions are going to come are going to be in those Practices which were relatively generously funded and haven't managed demand. So they're already going over-spent and they're already being bailed out by Practices like mine, who are getting a less good deal from the... in the big block hospital contract to ensure that those Practices stay within the 'one year waiters' and-and you-know the various other things. So I would think there's a cross subsidy of about somewhere between 7 and 9% of our hospital budgets, from us to other Practices. And that's going to create tensions unless... well it-it actually... one reason why it won't create tensions is because we know very well that we won't survive as individual fundholders under a new government, so we have to do it. So that, in a way, has restricted the tensions. But there's going to be tensions there if the higher, if the higher referring Practices don't do something to handle their higher referral rates and starts to do a bit more work in-house.

53 CD: Developing better management?

GP: Well, somehow our manag..., the multi-fund management has got to persuade the higher referring Practices that the GPs need to work up their own patients a bit more, treat them themselves a bit more instead of pass them on. That's going to be quite an interesting little battle.

CD: It still appears to be quite a challenging situation.

GP: It does, doesn't it just?

The interview had to come to an end. Although there were so many more questions I wanted to ask, a number of topics I would like to have explored further, it was time to go.

Chapter 7

Analysis

The Core Interview: Identifying Thematic Threads.

The core interview is just one of 15 interviews I conducted with GPs. In this and the following chapter I will analyse all the interview data. The variety of viewpoints expressed by the GPs, as they contemplated a very particular challenge, namely, the fundholding option, provides a further test of the validity of the research hypothesis.

Thus, the question I sought to answer from the interview data was what factors exerted the greater influence on the doctors as they contemplated the fundholding? Were the principles of modern medical ethics uppermost or other factors identified in this thesis as linked to the profession's ethos?

In this core interview the answer came in the form of a number of themes that emerged from it. I have already described the process used to identify these themes. They form the key elements in the thinking of the GP as he deliberated over the question of fundholding. They show up a concern with issues that this study has shown are linked to the ethos of the profession, including the long-standing desire of GPs for the status and respect granted to their hospital-based colleagues. In the main they are not concerns related to the principles of modern medical ethics.

The interview highlights the significance of context. This can helpfully be visualised as circles of varying degrees of influence operating around an individual Practice, or even the individual partners within a Practice. The operation of this range of influences is often expressed, either overtly or by implication, in terms of an ideal outcome and an actual outcome in practice. Between the two outcomes areas of tension are evident.

Thus, the narrative threads of interpretation, the analytical themes, can be seen in terms of these four main factors: circles of influence; ideal outcomes; actual outcomes; and areas of tension. These open the way to an explanation of the empirical data in light of the theoretical material that draws attention to the distinction between professional ethos and the principles of modern medical ethics and explores the relative impact of the two on professional thinking and practice (Strauss & Corbin, 1994, p.278).

Influence of Partners

The first, and possibly most powerful, of the circles of influence is that of the partners making up the Practice. Within the small business that is a GP practice, maintaining good relations in the partnership is understandably important. However, it also reflects an element of the profession's moral spirit, namely the importance of, in the words of one doctor "the collective commitment and solidarity" (Fitzpatrick, 2000), the *esprit de corps*.

In the paradigm interview the GP describes his partnership in very positive terms, an ideal partnership: “We’re very lucky in this partnership”(6). It is a stable, happy partnership with three of the partners having worked together for over 20 years and the remaining two having been with the partnership for almost a decade. They know each other well.

Ideal Outcome

Prior to becoming fundholders the partners had a big debate (6), the result of which was that everyone knew where everybody else was coming from. This, linked to the close-knit partnership, meant the ideal outcome was that the lead fundholder would be able to deliver what the partners wanted without the need to “write off two or three afternoons a week” with “everybody sitting down and deciding what they want”. The GP suggests that this ideal has been realised: “and so, in a way, you’re able to deliver what they want” (6).

Actual Outcome

However, other comments highlight a less than ideal outcome, his use of the phrase “in a way” points to a significant area of tension. Pressure of time hadn’t allowed partners to think through the issues so they tended to leave that to the lead fundholder. Thus, he had been expected to initiate as well as implement “the ideas” (3) .

Tensions

This situation created pressures when one or several of the partners thought the Practice was being taken in directions that they did not want it to go. Then they ensured that the planned changes were sabotaged (4). However, even this presentation of the situation glosses over the full extent of the tensions that might have arisen around the making of major decisions. Thus, whilst at one point the very hands-off decisions-making approach of the partners is presented by the lead fundholder in rather positive terms, at another point his comments suggest that he is less than happy with their response to priority issues. “It ought to be possible,” he says, “if it’s a priority, to make time” (4). But rather than make that time, partners left the decision to the lead and only reacted if and when they felt their own interests or priorities were under threat.

There is also the suggestion of a split within the practice along the lines of the three older partners, who had been together for 22 years, and the two more recent partners.

Partners and the Fundholding Decision

Prior to the fundholding decision itself, however, the partners as a whole not only met but had “a very big debate” (6), where everyone was able to express their views. This meeting revealed three out of five in favour of fundholding. Of the three, one partner seemed particularly positive, he was “convinced” of the need to pursue the fundholding route and appeared to have initiated the

whole discussion (6). Of the two who opposed the plan one changed his mind and the other abstained in the final vote (12).

It was in discussing the reason why the one partner continued to be less than fully supportive of fundholding that the tensions really came to the fore. At this point other factors that had impinged on and influenced the Practice were revealed. The motives of the one partner who maintained some degree of opposition were questioned. His stance was viewed as negative and hypocritical. Although he had presented his position as an ethical one, it was interpreted by his colleagues as an example of bending to the power that consultants had over GPs (15).

This whole scenario encapsulated the struggle between GPs and consultants; the historical tension between these two sections of the medical profession. Fundholding presented GPs with the opportunity to re-dress the power balance, GPs who failed to grasp the opportunity were just too weak to stand up to the pressure from the consultants who saw power shifting away from them. This struggle appeared in various forms throughout *this and all the other* interviews with fundholding GPs and was summarised by several interviewees in the phrase “consultants now send Christmas cards to us”.

The importance the GPs attached to re-dressing the long-standing struggle is a core aspect of the profession’s ethos. The profession had worked hard to achieve status and respect, but within

the profession itself status and respect attached to the elite group and not GPs. According to the president of the GMC (2001) general practice has always been viewed by the specialist as “the dustbin of medicine”, for those who had “fallen off the consultant ladder”. Fundholding gave GPs the first real opportunity to achieve status and respect in the eyes of their erstwhile superior consultant colleagues.

This emphasis on redressing the status imbalance is seen again in the second theme.

Influence of Relationship with Other Professionals

GPs work within a network of other professions and professionals. All these groups had some influence on the decision the Practice had made to manage its own budget. The relationship with each was changed when a Practice became a fundholder. From the fundholders perspective the influence was both positive and negative. That is to say, fundholding gave the Practice more influence in its relationships with fellow professionals, on the other hand those other professionals were often able to exert their own influence over the fundholders or potential fundholders. All these influences and counter-influences came through in the paradigm interview.

In relation to the PCT operating directly around the GPs, the Practice saw fundholding as giving them the freedom to structure the team in line with their particular needs. The paradigm

interviewee described “empowering” them: “Look, you know, okay, clean sheet of paper, what would you really like to be doing with [your] jobs?” Members of the PCT were “gobsmacked” because under the old regime their managers had never taken such an approach (16b). At the time of the interview, the Practice, working with the multi-fund, was in the process of extending the role of HVs in order to take some of the burden off the GPs. Other changes already implemented were making much more effective use of the team’s skills. Whereas HVs had previously been confined to developmental tests on nought to five year olds as fundholders, the Practice was in a position to extend their role to include running specialised clinics.

Beyond the opportunity to exercise more control over the immediate primary care team, fundholding was seen as giving the chance to loosen the grip of the HA with whom the Practice had had “major problems” (7). This body was seen as boring and conservative. In the eyes of the GPs affected by their management style and decision-making they appeared to know nothing about primary care. They were a shambles; more concerned about protecting their own backs than supporting good primary care. Thus, when fundholding came along, GPs saw the opportunity to shake off the shackles of this ineffective and inefficient bureaucracy. “We thought we could buy care better than the health authority could. And I think we were proved....right” (7).

Glennerster *et al* (1994), notes that prior to fundholding no-one at regional level had bothered to listen or take notice of GPs views. "GPs had never normally had any dealings with region...general practice had had a marginal status in most RHAs" (p.32, 34). From the perspective of fundholders the relationship with the RHA improved greatly. Certainly that had been the interview GPs experience: "Fundholding was...the blue-eyed baby of the Conservative government.... So...you could always pick up the phone to Region and have a bit of a moan at them and things got sorted out" (25).

The most dramatic change, however, was with service providers, local hospitals and consultants. Here the old relationship was turned around. Local hospital managers soon realised that fundholding GPs had choices, they no longer had to routinely refer patients to the secondary sector for treatment: "One queries much more whether it's worth using the secondary sector in certain areas where...20 odd years of experience has told you they don't deliver much and they are going to turn you out a bill of two or three thousand for it" (28). This was a change from the days when the GP had been left out in the cold by the consultant. Now the relationship had completely reversed.

Besides the freedom to undertake certain procedures in-house there was also the option to contract with providers outside the locality. All this gave fundholders considerable power. Holding the

purchase strings they could bargain for the best deal for their patients, negotiating to buy extra capacity at a cheaper rate (10). Such power was not enjoyed by their non-fundholding colleagues. Unsurprisingly that relationship also changed.

Former colleagues now found themselves on opposite sides of the fundholding divide. The relationship became very difficult. The interview revealed a considerable degree of mistrust and hostility between fund and non-fundholders. Over time this improved to the point where *the two were able to work together in a multi-fund*. Yet at the time of the interview there was still frustration at the way non-fundholders practised. Their apparent refusal to accept “responsibility for the costs they were generating...gobble[d] up a higher share of resources than they need” (44).

Ideal Outcome

Fundholding had an influence on all the professional relationships and in many cases that influence had been significant. Indeed, no relationship was unchanged. At every level, fundholding altered the established dynamics of the relationships. Whereas much of the primary care area had been “the poor relation of the health service and not getting a fair deal” (11), the interviewee saw the opportunity for altering that imbalance. Thus, the goal from his perspective was “changing the system”, “the pattern of health care” (16,36), and specifically the place of primary care in the overall

structure. That was the ideal outcome, at least in the medium term (16).

Actual Outcome

The interview GP highlighted resistance as the most common and sustained responses to these changed relationships. The political climate had forced an acceptance of the new structures but there was a sense of the superficial and temporary about that acceptance. The GP noted that they hadn't really changed the system. He mentioned that, in light of the new political situation, the RHA⁴⁵ was cooling off in its responsiveness to fundholders. The gains that fundholding had made were being lost.

However, the GP thought the relationship with fellow GPs had moved in a more positive direction. Initially there had been considerable hostility from non-fundholders but this had gradually softened and there had been a recognition that by redefining the GP/hospital and GP/health authority relationships, fundholders had broken new ground from which non-fundholders could benefit. Both parties were coming together in a commissioning group, largely due to trends they saw arising from the changed political climate, and "mutual respect" developed as non-fundholders saw the value of what fundholders had achieved. Thus, the back clinic that had been

⁴⁵ By the time of the interview RHAs no longer existed; in April 1996 their work had been passed over to the eight regional offices of the NHS executive. However, for much of the period covered in the interview "Region", the local RHA, had been an important element in the life of fundholding practices.

the cause of “a big row” between the two was now enthusiastically supported by its former “vociferous opponents”. Furthermore, he noted that “there is a view right across the medical profession, not just in fundholding but amongst the non-fundholders as well, that they can’t have their cake and eat it, that the health authority has finite funds and that we have to look at priorities. There is just as much enthusiasm for saying the health authority is wasting money here, you know, we shouldn’t be doing this, as there is for saying this is what we want more of” (45).

Tensions

Between the ideal of permanently changed relationships resulting from the influence of fundholding on the health care system and the reality of temporary and superficial changes, the GP identified huge tensions.

The ill-feeling that fundholding had created was indicated by his prediction that “a lot of people who very much resent the power shift to fundholding in health authorities and in Trusts are going to come pouring out of the woodwork to stab the fundholders in the back now” (41).

Consultants had strongly resisted the fundholding system fearing, according to the GP, a loss of their own power. He thought that one partner in the Practice had felt pressured into rejecting the fundholding option by the consultant’s opposition. Moreover, that partner was not alone in succumbing to such pressure. “There was

pressure brought, there were people feeling they were rocking the boat...upsetting the established hierarchy of things...and they felt uncomfortable with that”(15).

But it was not just weaker partners who caved in under the pressure from consultants. The interview suggests consultants placed pressure on each other not to give priority to fundholder contracts. The system created tensions. "It created tensions within the hospital...it created tensions within the medical community". And the judgement was made that this "was unhealthy" (18). Under this pressure the fundholders backed down. Thus, for example, the Practice "did actually allow" (16) its waiting lists to rise in order to relieve some of those tensions.

The GP described many consultants as disasters, as they continued to apply pressure in order to protect their own interests. He told how they were "constantly trying" to stop the Practice developing *in-house services*. One consultant had blocked every attempt on the part of the Practice to develop an ophthalmology service. Far from buckling under this pressure, the GP was even more determined to stand his ground: "I was going to make damn sure that those people [consultants] didn't control what I did in my building"(42). No suggestion on this occasion that a confrontation was "unhealthy".

Other schemes involving consultants providing services at the Practice, although recognised as "changing the pattern of health care

for the better” (36), floundered under various pressures. Thus, the GP quotes a consultant as saying of one such planned scheme “I really don’t know why we haven’t been doing that for the last 20 years. Patients are always saying to me ‘well why aren’t you going to do the operation doc?’ And I say well no I’ve got to put you on a waiting list, it’s going to be six months time” (36). “Despite an initial positive response, in the end “only the gynaecologist carried on with that scheme...The others all backed off” (38).

All these accounts suggest an ongoing power struggle. Each situation involved weighing up the strengths, either numerically or in terms of influence, of the opposition, or the popularity of the project, and then deciding on the best course of action, backing down or standing one’s ground. Thus, in the case of waiting lists the Practice had backed off, but on the issue of developing in-house services, the Practice, or rather the lead GP, had decided to pursue the matter as far as he could. On this latter issue, the positive stand seemed to have an element of the crusade about it and so met with considerable approval among his colleagues.

But, once again, the issues raised by fundholding and identified in this core interview relate to the profession’s ethos rather than its public principalist ethics. A power balance had changed and GPs’ status had been raised. The RHA and consultant now showed respect to the GPs whom they had formerly hardly taken the trouble to notice. Nevertheless, first wave fundholders, in particular, had

broken the united front the profession wanted to present to changes that its upper echelons strongly opposed. They had “rocked the boat and upset the hierarchy”(15). That action had, in the experience of one first wave fundholder, resulted in colleagues treating them like "Christians in the arena" (BMJ, 1996). Although, according to my core interviewee, himself a first waver, the tension had eased, over time there were still problems with relationships. Indeed, he saw new tensions on the horizon with both non-fundholders and fellow fundholders.

Influence of Political Climate

This influence was identified in the interview as operating from two levels, national and local. The Practice saw itself as vulnerable to the winds of political change and this had influenced and continued to influence its decisions.

Thus, it was the action of national government that had first pointed the Practice in the direction of fundholding. The partner who pushed for the Practice to take on fundholding did so because he saw “what the government of the time was doing” (6) in targeting resources. There was a sense of threat inasmuch as those Practices that refused to take the fundholding route would find themselves starved of funds.

However, at the time of our interview they were aware of a possible change in the political climate. If national government lost interest in fundholding it could very easily destroy it. “It doesn’t

have to pass an Act of Parliament, it just has to tell health authorities to knock everybody's budget by 10%...The whole thing becomes unviable...you've got to walk away from it" (21). For that reason the partners had begun to work more closely with other fund and non-fundholders in multi-fund and commissioning groups. This was also a direct result of the changing political climate. "We won't survive as individual fundholders under a new government, so we have to do it" (52).

But small 'p' politics at the local level also had a considerable health influence on the Practice's decision to pursue the fundholding option. The partners saw a health authority management too wrapped up in the politics of protecting their own jobs to make any sensible decisions about the delivery of primary care (7). Thus, they decided to take control of their own situation rather than leaving it in what they considered to be incompetent hands.

However, once they had become fundholders the Practice found that the politics often worked against their entrepreneurial efforts. In theory, they could "buy better care" for their patients but in practice they were often defeated by the internal politicking. In the interview the GP spoke of efforts they had had to make in order to "defuse the political problems" encountered because they were fundholders. Later he narrated a lengthy tale to illustrate the impact of these political pressures on the delivery of health care in the locality. He believed that "at least half the stuff that's done in hospital could be

done in the community” at up to half the price. But when, for example, the Practice offered its minor surgery services to the health authority the response was wholly negative. “The health authority is so wrapped up with big hospital expenditure that it simply hasn’t been able to withdraw funds out of the hospital” (38).

Similarly, after “a big row” with non-fundholders, the Practice decided to invite them to send urgent cases to the fundholder’s back clinic because they had objected to the service giving fundholders’ patients an advantage over those of non-fundholders. However, on that occasion the offer was refused because it was seen as taking a service away from the hospital: “Ooh, mustn’t have our patients sent there, two-tier system, it’s all in the community, must be in the hospital. Terrible” (39). Everyone had their, often very different, political agendas and finding a compromise position was far from easy.

Ideal Outcome

The interview suggested two ideal outcomes in relation to the influence of national politics on fundholding Practices. First, that government would pursue clarity and consistency in health service policies in general: “in terms of the detail we want to see where we’re going in the health service” (24). And in the area of a very specific policy, what should or should not be funded within the NHS was a decision national government had to make rather than pushing

it down to the health authorities or even individual Practices. “It would be much easier if centrally a decision was made that this was not an effective mechanism and, therefore, it would not be part of NHS treatment” (32). Secondly the GP wanted to see less bureaucracy; less regulation (41). Freedom to practise was the ideal.

Actual Outcome

GPs had to cope with an ever changing political climate, having to keep an eye on the signs. “Reading the tea leaves” (40) had become very important, but recent change in government had increased the sense of uncertainty (24) and made reading the signs “a bit bloody difficult”. There was also a need to keep track of the movement among various bodies and interest groups who were themselves “reading the tea leaves” and adjusting their relationship with fundholders accordingly. Thus, Region, for a brief period so responsive to the blue-eyed fundholding baby, had begun to cool the relationship (25). Still the fundholders felt their hands tied in too many areas by too many vested interests.

Tensions

The tensions created by fundholding, created in turn a new need to play the political game. The GP seemed to have relished some of the battles finding the challenge of pushing against and overcoming the opposition and obstacles a new and exciting aspect to add to the everyday work of a GP. The “heady atmosphere” of meetings to discuss strategy and tactics, the negotiating and hard-bargaining

(Glennerster *et al*, 1994, p.97) all find echoes in the events recounted by this lead fundholder in his dealings with partners, consultants, and the health authority.

Nevertheless, pushing for the ideal and having to accept the compromises of actual practice was also deeply frustrating. Changing attitudes was "taking a long time" (17), there was "still too much control in the system to really innovate" (41).

Influence of Patients

Within the context of fundholding, patients exerted a range of influences, both passive and active, over the doctors.

a) passive

Much of medicine is about direct contact with and care of patients, so simply by reason of the fact that they were patients they exerted an influence. Thus, the Practice opted for fundholding in order to ensure "better health care for our patients"(10). The GP evidenced genuine concern for the needs of their patients; there was obvious sympathy for their distress and an understanding of their desire for even some small relief.

Discussing the expectations of the average patients the interview GP asked rhetorically "what do you want when you go into the doctor's consulting room?" and answered "you...want, I suspect, some sort of body language and words which do convey some sort of interest in you as a person"(47).

Ideal Outcome

The traditional and ideal relationship was that of the doctor acting solely in the interests of the individual presenting patient. The role of doctor as patient advocate: "the doctor's supposed to be there to ... be the patient's advocate and get the best ... he can for that patient"(29).

Practice

Such advocacy no longer had a place in the NHS. The core interview makes clear that fundholders in general recognised this, not so much because they had become fundholders but rather because "there was no pressure on patients to control their demand", so the NHS as a whole found itself having to meet more and more demands with fewer and fewer resources. In those circumstances Practices had to move from being patient centred to being community or population centred. GPs were "beginning to have to view things in terms of the good of the community rather than the good of the patient"(29).

As for GPs who wanted to follow the traditional ideal; "if they wish to be the patients advocate and give the patient everything the patient needs, they have to be in the private sector" (43).

Tensions

It was around this issue that the interview GP identified what he described as a conflict; a constant dilemma. This came across very powerfully as he talked about a hypothetical patient with MS (Multiple Sclerosis) and at that point there was a real sense of an

individual doctor struggling to come to terms with the new context within which the patient had now to be set. The GP addressed it in the third person perhaps because it was a challenge that he personally was still finding it difficult to face: "He's beginning to have to view things in terms of the good of the community rather than the good of the patient" (29).

Whereas he used to be able to say to a patient of any treatment "let's at least give it a go", now he found he had to say no (30). A very uncomfortable position in which he would clearly have preferred not to have been placed. In his opinion the government had been "deliberately naughty" (32) in exposing GPs to that type of decision making.

It was interesting to hear the example which he chose to illustrate the dilemma. "Ten thousand quids worth of non-effective health care", "a busted flush"; against twenty patients receiving effective treatment for cataracts (30). This approach oversimplified the dilemma and again indicated the difficulty the GP was having in facing the reality of making the really tough rationing decisions. Or perhaps the problem was reluctance to discuss the true nature of the situation with a lay-interviewee, an outsider.

b) Active

There was an anxiety that the Practice's decision to become fundholding would change the attitude of patients to the care on offer, that is to say, they would expect, and even demand, special

consideration. For this reason the Practice decided not to advertise *its fundholding status*.

Ideal Outcome

The thinking seemed to be that if doctors did not talk about the Practice as fundholding then patients expectations for, for example, quicker referral or non-standard treatment, would not be raised. On the other hand, because they were now responsible for controlling their own budget the doctors would be free to make decisions about patient care that took into consideration costs involved. Thus, “all the evidence is that for 95% of conditions in general practice the old-fashioned, cheaper, generic products get just as good results and you can, you know, save a lot of money by using them. ... the patients aren't suffering... and you're freeing up money for other things” (19).

Hence, the ideal situation in the doctor patient relationship was that the patients would be “very good” (50) and not make unacceptable demands of the budget whilst at the same time the doctor, without any obligation to inform the patient, would make treatment decisions that could, if circumstances dictated, take account of the cost element.

Actual Outcome

Unusually in this situation, the ideal seemed, in the opinion of the GP concerned, to have worked out in practice, apart that is, from

a very few patients who had "pushed it" (50) by expecting that a fundholding Practice could arrange for them to receive some preferential treatment.

Tensions

In the main, therefore, the anticipated tension between doctor and patient had not arisen. However, there were "various strategies" for dealing with patients who stepped out of line and made what were seen as unacceptable demands on the budget along the lines of "you're a fundholder, you've got the money" (32). Usually this involved some sort of stone walling "I'm sorry...even though we're fundholders we're not prepared to fund procedures that are not available to non-fundholders"(32). However, the GP admitted that this was not easy.

The medical profession's ethos encourages an attitude of "excessive paternalism" toward patients. This traditional moral tone, rather than the modern principlist medical ethics of open discussion based on patient autonomy, informed the overall approach of this fundholder to his patients.

Influence of Managing the Budget

In the main the interviewee spoke very positively about the partners' decision to manage their own budget. He emphasised that they had been influenced by the opportunities they saw holding their own budget affording them. These opportunities fell into three categories:

a) Control

The major incentive was that it offered them the chance to take control of many elements of decision-making that had previously been in the hands of “bureaucrats” who appeared to know little about primary care and the GP/hospital interface (7). Too often most of the money and attention had been focused on the hospital service, and primary care saw itself as the poor relation to the often glamorous secondary care sector. Fundholding allowed GPs to “keep their eye on the ball” in relation to allocating resources to primary care.

b) Savings

Managing their own budget so offered the chance to make savings that could then be ploughed back into the Practice. In the paradigm interview, the GP is proud of what his Practice had been able to achieve with their savings. He was quick to emphasise that all had gone into directly improving services to patients: “we did actually only get 50Ks worth of savings from the fundholding. But that allowed us... all that 50K was spent on resources for health visitors, district nurses, and CPN service, and that sort of thing. So it wasn’t actually spent on the GPs, it was spent on ancillary services” (16). This had been a particularly contentious area between fund and non-fundholders, the latter claiming that the former were finding ways of making and keeping back “profits” from their budget.

Prior to fundholding there had no incentive to make savings (16,33). The Practice saw that non-fundholders still lacked that incentive and so, were wasteful of NHS resources.

c) Management Values

Taking responsibility for their own budget required the Practice to adopt management values and learn new management techniques. The GP saw this development in very positive terms. "I feel perfectly comfortable with it and I think what fundholding has taught me is that good management is good management" (46).

Ideal Outcome

Ideally, fundholding should have offered the opportunity to make a significant difference in those areas of most concern to patients, particularly around the issue of waiting lists. In the paradigm interview, the GP said he believed that because of the major efficiency savings that could be achieved by ring fencing, what he called the manageable part of health care, cold procedures as against emergency treatment, the Practice could have virtually abolished its waiting lists (10 ,16).

Furthermore, beyond improving waiting times fundholders could actually raise the standards of secondary care offered to their patients. Thus, the GP described in some detail the situation in his local hospital prior to fundholding where the theatres were effectively closed down for considerable periods due to a lack of resources thereby forcing up waiting lists. But there was a way

round this problem. "If you ring fenced the money for cold surgery, obviously you could then plan it, you could use those theatres effectively and you could bring unit costs down. Had to happen. So the more I looked at it the more I realised that if we had a ring fenced budget for those sort of, you know, those sort of procedures we could plan it, decide what our resources were, buy extra capacity on the margin at a cheaper rate, bring our waiting lists down...and deliver...better secondary health care for our patients" (10). It was having control of their own budget that allowed GPs the freedom to ring fence resources for cold procedures. This was only one way in which patient care could be improved.

Holding the purse strings also allowed fundholders to have some control over the quality of care delivered at the secondary level. This was because they had the "power of exit" (Glennister *et al.*, 1994, p.79). If a local provider failed to provide the service they required, fundholders had the freedom to take their business elsewhere, including into the private sector. Although the GP did not make specific reference to this aspect of fundholding in the interview, he clearly referred to its consequences. The issues came out in section 16 where he implied that the Practice had considered taking their contract away from the local hospital. A decision that would have involved "moving patients around" by going out of the area.

GPs could also redirect resources within the Practice itself, making savings in one sector and boosting spending in another. Thus, the GP mentions how, in his Practice, they had used savings from their drugs budget to “put a bit of extra money into primary care” (16).

General medical services could all be improved by adopting good management techniques. The management skills necessary for running the budget efficiently should have had a beneficial “fallout effect” on the way the Practice as a whole was run. Thus, the way in which patients were dealt with on the telephone, routine appointments were arranged, emergency appointments handled, and even the attitude of doctors toward their patients reflected in, for example, the body language they used (46,,47), could all be influenced positively as a Practice developed good management skills.

The experience of managing the budget made the GP realise the importance of good management throughout the NHS. “A publicly funded health care system, because it’s so short of money, has to be, to my mind, managed in a first-class way” (51).

Actual Outcome

The GP acknowledged that *much of what was supposed to have been achieved by fundholding could have been realised by the much*

simpler process of ring-fencing the primary care budget. "You didn't have to invent GP fundholding to ring fence that funding" (11).

There was the danger that if fundholding Practices took their contract away from the local service provider, then it might have been forced to close down. This seemed to have been the position faced by the Practice. By giving their contract to an outside provider they would have deprived all patients currently using and wholly dependent on the local provider. This consideration curtailed some of the ventures into non-local contracts.

The GP saw fundholding as, at best a medium term venture. "What I said to my partners when we embarked on it [was] 'I think we've got five years on this, after that everything's going to tighten up and it's time to drop it'" (20).

He also recognised that the high value he placed on good management was not widely held. He detected an inclination to save money by reducing management costs. This, in his view, was "the big trap" (51) that would lead not to improved patient care, but a badly managed service.

Tensions

The paradigm interview identified a number of tensions that were directly related to the holding of a budget. Pressure came both from non-fundholders, but more surprisingly, from other fundholders.

One concern this first-wave fundholder expressed was that the budget allocated to the Practices should be “fair”. He well recognised that “an excessive budget” would create tensions (12). So it proved. Although the Practice was not particularly well-favoured, being the fourth lowest funded per capita of all the fundholding Practices in the area, “people assumed we had more money than anybody else”(16). This created “a backlash” from several quarters (16), including the hospital where “some of my friends who are consultants”(16a) found themselves under pressure when they gave *priority to the Practice’s patients* “because we’re bound on the contact” (16a) The situation became “difficult” and the Practice had to rethink its policy.

However, the major tensions arose between Practices and centred on the perception that fundholding had created a two-tier service. The paradigm interviewee describes a “big row” because his Practice had been able to use their fund to set up a back clinic for their patients, resulting in speedier service. This was seen by non-fundholders as proof of a two tier service with their patients falling *into the second tier* (39).

The GP’s response to this accusation suggested well rehearsed and oft-repeated arguments. Fundholders were innovators trying out, on behalf of all their colleagues and ultimately for the good of all patients, new methods of delivering good health care. Once the fundholder had tested out the “pilot scheme” it could then be “rolled

out for the benefit of everybody”, if the necessary structures were in place(39).

In the short term, schemes that proved successful gave advantage to patients in the pilot area. It was up to all the bodies concerned to make that a temporary situation by ensuring that the “playing field was levelled out” so that the good ideas piloted by fundholders could be “taken forward”(39,40). The implication was that fundholders could not be blamed if those bodies were unable to get their act together in order to take advantage of the piloted schemes.

There had been some positive movement in this area of tension through the work of what was described as “ an extremely good commissioning group”(40). Where such a group did not exist there were still problems.

Other positive developments such as the creation of a consortium of fundholders and non-fundholders, “big consortium with a representative from each Practice” (45), had also led to a reduction in some of the tensions. There was, for example, a much greater recognition in all Practices of the need to “look at priorities”, that they could no longer “have their cake and eat it”(45).

But others tensions were arising, particularly as groups of Practices were having to learn to work together in anticipation of further government changes. Well-managed fundholders found themselves having to bail out the less well-managed, in order that all

in the multi-fund could meet their required targets: "The multi-fund's management has got to persuade the higher referring Practices that the GPs need to work up their own patients a bit more, treat them themselves a bit more *instead of passing them on*. That's going to be quite an interesting little battle" (52).

There was also the potential for tensions within a Practice as it sought to keep inside its budgetary limits and to make savings. Pressure on the drugs budget meant "you could almost say that GPs in general are not spending enough on some drugs" (19). There was also the temptation to provide cheaply in-house, that which would be better provided, in terms of quality of care, in the secondary care sector (36). GPs had to recognise that they could be directly responsible for damaging patients if they paid too much attention to the cost of treatment. This was a far from comfortable ethical position. While the GP was at pains to insist that in his Practice they knew where to draw the line; they had their priorities right, there was also an awareness that others might not be quite so careful.

According to this first wave fundholder, a strong motivation for pursuing the fundholding option was the independence it gave from outsider control. Managing their own budget removed at least some of the restrictions of the old arrangement. This emphasis on independence and freedom from outside constraints is an attitude fostered by the profession's ethos, its underlying moral sentiments.

Summary

The interview data shows that the well-being of patients, particularly through the provision of better primary care and more control over the quality of secondary care, was a significant consideration in the decision to become a fundholder. It is noteworthy that the only issue which the GP felt created a personal conflict, and that he referred to as “this constant dilemma” (30), revolved around the place of the individual patient in a system that increasingly had to move away from what was perceived to have been its central role, namely, personal advocacy, toward care of the community. He was clearly exercised by the conflicting claims of his own desire to meet the needs or expectations of the presenting patient and “the lessons of responsibility for costs” (43), that is to say, the duty to maximise health care provision for the whole patient population through the wise use of limited resources, even if that meant denying an individual patient a particular form of treatment. Advocacy had to take second place. In this context it should be remembered that, in the view of its leaders, “advocacy” is a core value of the profession and as such, one of its “greatest assets” (Allen, 1997a, p.3). Beyond that concern, however, the data highlights the contradictions and confusions in this emphasis on the care of patients.

Patient care was one among a number of other areas of concern that included the relationship with colleagues. More than that,

throughout the interview with comments such as: "the power shift to fundholding" (41,); "upset[ing] the established hierarchy of things" (15 -); "those people (consultants) not controlling what I did in my building" (42); the GP showed his concern with issues of control, of status, of re-dressing imbalances in power, and of independence. Historically, these are characteristic concerns of the profession as a whole. They reflect the profession's underlying moral tone, its ethos - that focus on itself as a superior and noble profession - but not the principles of modern medical ethics. I now turn to the interview data as a whole to find if it confirms the emphases of the core interviewee.

Chapter 8

Ethics and Ethos: Pulling the Threads Together

(Other Interview Data)

This chapter is divided into two main sections allowing the voice of both fundholding and non-fundholding GPs to be heard. Thus, there will be some conflict between the ideas expressed. In hearing these conflicting ideas, it is essential to ask whether they weaken or undermine the core argument of this study; namely that the traditional medical ethos, and not the more recently developed principalist medical ethics, is the greater influence on professional thinking and decision-making? Which set of factors or values played the major part in the decision on fundholding? Principles of beneficence, non-maleficence, autonomy, and justice or those informed by the profession's fundamental moral sentiments, namely, traditional practice, protecting independent status, and enhancing professional standing?

Unless indicated otherwise, all the quotes in this and the following chapter are taken from the 15 interviews I conducted. Quotes from the core interview are numbered, the rest, for reasons given above (see p.218), are distinguished only by reference to features I judged important in the context of the quote and especially whether the views are those of a fundholder or non-fundholder.

A brief profile of all the GPs interviewed, other than the core interviewee, are provided in Appendix D.

Fundholder Interviews

Influence of partners

In all but one of the interviews, the views and feelings of partners had a significant influence both on the decision to become a fundholder and the way the fundholding programme was implemented. Thus, in one, two partner Practice in a small town, the younger of the partners was the driving force behind the move to fundholding. The two, who had split off from a larger Practice, seemed an unlikely partnership. The younger, dynamic and forward-looking; his older colleague rather more set in his ways. Although the older partner only "acquiesced" to the move into fundholding, his more conservative approach dictated what changes were implemented and how. "We can make major changes where there isn't much controversy. Where there is controversy your ability to manoeuvre is a bit more limited". In the younger partner's view, his colleague, a man in his fifties, was an "old timer", for whom issues such as clinical autonomy, the freedom to prescribe the drugs or treatments he wanted, was an absolute essential. Any effort to "reel in prescribing" resulted in some very defensive behaviour, "you're threatening their manhood". In these sensitive areas, the younger partner took a cautious approach attempting to make the changes he saw as necessary without "upsetting the apple cart". Nonetheless, despite the obvious reservations felt by the older partner, the younger had pushed for fundholding "Primarily I had to protect the business side of the Practice". He saw it as the only way the

partnership could achieve the rigour required to survive in the much more cost conscious NHS. When I spoke to the older partner, his initial reluctance seemed to have disappeared and he had come round to see the benefits of their new position.

In one large town-centre Practice, there were “moral objections from some of the partners”. However, the partners as a whole “looked at the potential benefits...[and] decided that, on balance,...fundholding offered our patients a better deal”. Once the decision was made everyone agreed to go along with it. A similar position was taken by another many-partnered, small-town Practice. The partners had spent what they called an “away day” together looking at the pros and cons of fundholding and had agreed that, despite reservations, fundholding was the way in which the Practice had to go.

There was only a single exception to this general approach. The doctor concerned, a first wave fundholder, was a senior partner with strong views who presented himself as disinclined to brook dissent from his preferred position. My suggestion that the views of his colleagues had played any part in his decision was dismissed out of hand, as, indeed, were virtually all the questions I wanted to raise. In his firmly stated opinion, fundholding raised no ethical concerns whatsoever, doctors knew exactly where to draw the line between the business and the medical side of running a Practice. It was something they had been doing long before fundholding came along

and they had never confused the two distinct elements. This was the briefest of all the interviews, a mere 15 minutes, and it soon became clear that the only reason the doctor had agreed to be interviewed was because, in his view, fundholding was erroneously seen in a negative light and he wanted to take every opportunity to "set the record straight". He was unwavering in his support of the system, and from the strength of his views, it appeared that political considerations were a powerful influence on his decision.

Once a Practice had become a fundholder the influence of the lead fundholder partner seemed significant. All but one of the other interviewees referred to the strength of the leads' position. The exception was a Practice where a relatively new young partner had been given lead fundholder responsibility. What made this situation interesting was the fact that the senior partner had been the lead until a few months earlier. He had relinquished that position to a very junior partner for reasons connected with maintaining a distance from direct management of the fund. Despite this "disconnection" the senior partner still seemed to have the greatest say in how the Practice actually managed its fund.⁴⁶ In all other cases, lead fundholders described themselves, or were described, as having considerable influence over the Practice of their fellow partners. This

⁴⁶ I will not go into further detail regarding this particular lead fundholder as to do so may make it possible for the lead and the practice concerned to be identified. The situation within that practice was rather unusual.

was particularly evident in matters of keeping within the prescribing budget. “Our lead is very good. He always lets us know how things are going. So we know what we can afford to buy and what we can’t”.

A lead fundholder described his role as follows: “We've taken away from partners worrying about anything to do about the money”. The partners only had to concern themselves with clinical decisions based on patients needs. However, the lead saw it as his job to “point out to them certain areas where they might use resources better”. And, if he thought a treatment unusually expensive he would have a quiet word with the partner concerned “and just ask why?”

“Gentle manipulation” was one description of the role of the lead in guiding partners spending decisions. It reflected the general approach of all leads, bar the youngest one whose situation I have already described. Partners appeared content to accept this influence over their clinical decision-making, even though it appeared quite an intrusion on their clinical autonomy. They were well aware that there were financial implications for the Practice if it went over budget, for example, in its prescribing costs. In the context of the Practice as a small business, clinical autonomy was less important than keeping within budget.

Influence of Political Climate

The position of the GP who seemed to have a strong political/ideological commitment to fundholding, was, exceptional. Nevertheless, for the majority of GPs, awareness of the political climate played some part in the decision-making process. Indeed, three of the fundholders spoke of being “driven” into fundholding by their perception of political developments as they related to medicine in general and community care in particular.

‘Fundholding was the way things were going and we are probably going to be doing it, so we might as well get on with it’ was how one fundholder, an enthusiastic one at that, expressed the way his partners had read their position.

For the two reluctant fundholders among my interview group, pressures of the political climate played an even greater part in pushing them into taking the fundholding path. “It was made so uncomfortable to stick to your principles”, one of them said. “Pragmatically the decision was a good one, it was the way we had to go...and that overrode our personal feelings” was how another summed up the thinking behind the decision.

A majority, (8 of the 10) of the fundholding GPs expressed reservations as to the political thinking behind the scheme. Like the core interviewee, they saw it as “naughty” of government to divert attention away from its own responsibility for underfunding in the NHS by apparently passing funding decisions over to local GPs. Fundholding “was another ploy of [the] government. They thought

‘right, we’ll off-load all responsibility for the health service by making doctors fundholding and you can blame them when things aren’t going right.’” “Fundholding’s been a political expediency”.

In the midst of all the changes, GPs were staying alert to the political situation as it affected their position, “keeping my nose in the air”, was how one put it. For that reason, a large number of the fundholders in one locality had banded together to form a local multi-fund. This move was, according to one interviewee who had recently joined the multi-fund, driven by an awareness of a possible change in the political climate. As he explained: “Politically everybody expected that aggregation was going to be the way to go. The idea of multi-fund got in ahead of the election. Rather than people being told what to do they made a pre-emptive strike and started to aggregate”.

Four of the interviewees pointed to local political manoeuvrings having played a part in pushing them into fundholding. There was considerable disapproval of the way the local health authority had performed on behalf of GPs. “We were unimpressed to say the least”. “We thought we could do better ourselves”.

Influence of Managing the Budget

One of the main areas of concern about managing the budget was the time it would take. Nine of the fundholders I interviewed

mentioned this as an issue. Within the partnerships it had been the most commonly raised objection to fundholding.

Among fundholding Practices it had been an important issue. "Most [of the partners] were nervous that it would involve a lot more work". This concern led several of the lead fundholders to try and "make fundholding as invisible as possible". Four of the Practices kept a separate team just to look after the fundholding side of things. In one small Practice on the other hand, the lines were blurred and crossed virtually all the time: "this is a small organisation and staff cut across both the core business and the fundholding side". In the remaining five Practices, the lead fundholders stepped aside from their medical duties during a given period each week, a morning or afternoon, to focus on fundholding work. Thus: "Every [Tuesday] morning I'm here but I'm not here. So my patients may see me in the building but they will be seen by one of my partners". "If you are well organised it only takes a few hours every week, one afternoon and everyone knows where I am and what I'm doing".

Whether managing the fund was visible or invisible, it did take time away from direct patient care. Nonetheless, all the Practices considered this a worthwhile sacrifice, the benefits of managing their own fund far outweighed this drawback.

Managing the budget brought a rigour into the Practice that was perceived to have been lacking before. This rigour was mentioned by eight of those interviewed as a significant reason for adopting

fundholding. The fact that "doctors are not intrinsically managers" was a weakness "we muddle through, there is no focus". Fundholding "brought us up to scratch"; it was "a way of getting much needed skills in place". "We had to be in a position to know where we were going and how to get there". "Managing within budgets is going to become the norm, having to apply best business practice to the provision of health care".

In one of the small partnerships it was because one partner failed to "perceive the weakness of our business position" that, in the view of his colleague, he was reluctant to take on fundholding. For the pro-fundholding partner, taking responsibility for the budget was the only way to ensure the survival of the Practice. Without that move he could see the Practice "going down" into bankruptcy. Another doctor with whom I raised this possibility denied that such a thing would be allowed to happen. However, in the experience of the first doctor, health authorities in other areas had done just that, "let the whole thing go". In his assessment of the Practice's position, *fundholding had proved its salvation.*

The new responsibilities that managing the budget imposed was the single element that, in the view of one very pro-active fundholder, "frightened many GPs off...they don't want to be responsible". Of those prepared to take up the new responsibilities some saw it as a necessary evil. "A new game was being played and you either learnt the rules and got on with it or you stood on the

sidelines jeering but being left behind". Others found the whole experience "refreshing" and even "exciting". No matter the attitude with which they entered "the game", all those prepared to accept the responsibility did so because they also saw the opportunities.

Improving the Practice by updating equipment, adding new technology and expanding the premises was an obvious incentive. Even a very reluctant fundholder described one of the major benefits as "to the Practice itself in the sense that we've been able to update our technology and space". All such improvements could be justified in terms of improving the quality of care offered to patients; a central tenet in medical ethics; but they also added value to the partners holdings, a significant factor in the ethos of GP practice. Thus, one interview was conducted in a splendid boardroom. The GP and I sat at one end of a large and rather handsome oak table. Here the partners met one afternoon every week to discuss matters of import. This room, along with a range of other refurbishments and additions to the building, was a direct result of the Practice becoming a fundholder.

All the fundholding GPs insisted that they were able to resist the temptation to save money by not using the secondary sector when it was in the patients best interests to do so, although they also all agreed that some of their colleagues might be less scrupulous and, indeed, the paradigm interviewee had noticed a tendency to under-prescribe in some areas due to the pressure on the drugs budget.

A fundholding GP with whom I raised the question of savings, responded by pointing out that their refurbishment had improved efficiency and effective delivery of care by bringing all the administration under one roof, thereby opening up "a lot more clinical space" for more doctors and more nurses. However, there was a degree of discomfort at my having raised the issue. "Is it wrong putting money into buildings or is it a question of who owns that building? I think the rub is there....It is difficult...Not a lot of NHS money has gone into this improvement....This is a one off and it's actually very, very small and do I benefit personally? I suppose at the end of the day if I sell it off but most GP surgeries are running at negative equity".

Later in our conversation, the same GP spoke with concern of a plan afoot to open a home for people with learning difficulties that would have to be served by his Practice. His concern was that as the Practice already had such a home in its catchment area a second one would put considerable pressure on the budget. The partners were determined to resist this development and were engaged in trying to persuade neighbouring Practices to at least share the financial burden with them.

There was, however, among those interviewed, one case of a fundholding Practice where they had decided to return their savings to the local health authority rather than use them to refurbish their building. In explaining their decision the lead fundholder told me:

“We didn’t feel morally comfortable to use fundholding savings to develop that which is owned by the partners”. Even here, however, the action was probably not as selfless as it appeared. Profit of another kind seem to have been a strong motivating factor, inasmuch as one of the partners had become actively involved in the politics of the profession and was anxious to avoid using the money saved in any way that could be interpreted in a negative light. Nevertheless, that the partner involved saw the question of how savings were used as a potentially damaging issue suggested that using savings to improve buildings and the like was not quite as patient centred as most fundholders liked to insist. However, the Practice did not return all the money it had saved, but used some of it to set up a counselling service for its patients.

Influence of Patients

The influence of patients centred on the question of how fundholding would affect patient care.

None of the Practices had consulted patients about the fundholding decision. Glennerster *et al* (1994), found the same lack of patient involvement in his study. This was unsurprising, as in traditional medical thinking patients are passive recipients of care. However, virtually all of the Practices, both fund and non-fundholders, stated that their decision was based on a desire to provide “the best service for the patients”. Even though the majority

of fundholders I interviewed were, to a greater or lesser extent, conscious of the need to take their patients sensibilities into consideration this was very much an interpretation of what those sensibilities might be. There was no direct discussion with patients.

This paternalistic approach reflects a central element of the traditional medical ethos where the expert doctor looks after patients who, in turn, are expected or required to do no more, and no less, than follow the doctor's advice or "orders" (see footnote 14).

However, one Practice, when tightening up on the drugs budget, decided to set out the aims of the Practice. Patients were given this information on the repeat prescription schedules held by individual patients. The Practice considered it very important that patients be given information and kept abreast of developments that directly affected them. In another Practice, the aim was to "lift a very poor generic prescribing rate...to way above the local averages". In order not to upset patients, the Practice moved gradually over a twelve month period toward its goal. They adopted what was described as a "bottom up approach". "We took the patients with us". The goal was achieved "without upsetting anyone".

Nevertheless, all but one of the GPs I interviewed saw patients in very passive terms. One GP thought his patients wanted nothing more than to be "taken by the hand and led through the system" until they came out of the other end with their health problem resolved. In the core interview the GP suggested that patients were satisfied as

long as they saw some sort of body language from the doctor that conveyed interest.

A more active involvement by patients was not welcomed or tolerated. Patients who tried to be knowledgeable about their health needs enraged one GP. He dismissed their efforts as “the classic Reader’s Digest Home Doctor’s Almanac”. Several of the fundholding GPs referred to the potential problem of patients asking for specific types of treatment. “You’re faced with someone saying they need aromatherapy or something, and asking us to pay just because they’d heard we’re fundholders”. None of the GPs were prepared to acquiesce to their patients wishes. All had “strategies” for fobbing off such requests. These basically involved telling patients a version of the truth to the effect that the Practice “was not allowed” to purchase treatments for its patients that would not be available for all patients “We just cop out” as one GP put it. In one Practice the partners had made a point of explaining to any patient requesting unorthodox treatments, that they had made a ‘collective decision’ not to use their funds in that way. “We have the good of 9000 patients to consider as against one”.

In one of the many Practices where the decision had been made to support the local NHS provider, the GP recognised that patients may well have preferred to receive speedier treatment even if this meant going into the private sector, but they were not offered this option. However, in the same discussion the GP made clear that

their support of the NHS was conditional. If the private sector offered better value for money, the Practice would have no qualms about using it. Speedier private sector care could become available to patients, but only if and when it directly benefited the Practice budget. It was for doctors alone to make the decision. It was not an area over which patients would be invited to express a view.

Only one fundholding GP positively welcomed active patient involvement, but then only up to a point. "I think you can involve people in the dialogue". Indeed, he found it stimulating and learnt a great deal particularly when patients brought in information they had sought via the Internet. But as for inviting patients views on fundholding and the spending constraints it had imposed: "I don't directly allude to it...I tend to dress it up in certain ways".

Three of the fundholding GPs thought fundholding and the other related changes had altered patients attitudes toward their doctor. "The esteem in which GPs used to be held" was fast disappearing. There was much less trust and respect, and consequently people tended to visit the surgery, or even call the doctor out, for all sorts of trivial problems. One GP was particularly resentful of this change. Where patients once appreciated what the doctor did for them and were grateful, now the trend was towards a more proactive patient demanding "their rights". Although small in number, in his opinion, this unappreciative band, influenced by the Patients Charter, was growing. The negative attitude of patients had, in turn, affected

the attitude of GPs to the care of patient. Where once he and his partners eschewed all thought of working nine to five, now, simply in order to survive the “patient onslaught”, they along with many of their colleagues, were using a deputising service despite reservations as to the quality of care the service offered.

Fundholding had made all the GPs very aware that treating patients cost money. Not only in terms of the obvious direct costs in pound and pence of any treatment but also of what economists call “opportunity costs” (Cole, 1995, p.57). In other words, a decision to purchase one type of health care, involved not only the actual outlay of money but also the loss of the opportunity to spend that money elsewhere and thereby satisfy the needs or wants related to that alternative. The cost of one hip replacement included not only the actual pounds but also the opportunity to purchase 20 cataract operations with all the utility that those operations would have brought to the many patients involved. Opportunity costs have always been part of the spending dilemma for the NHS. However, until fundholding, it was not part of the GPs job to take account of that factor. They could push the decision further down the line, leaving it, for example, to the consultants and their waiting lists. Fundholding gave GPs a “direct say in the rationing criteria that would affect their patients” (Glennerster *et al*, 1994, p.49), and the incentive to make savings both by buying cheaper secondary care or even deciding not to send patients to the consultant in the first place.

Influence of Relationship with Other Professionals

Interview material indicated GPs often felt undervalued by their professional colleagues and those in higher levels of management. Fundholding was a way of raising their profile and giving them the recognition and respect they felt their contribution to health care deserved.

All the fundholders described the change in the relationship between GP and consultant that fundholding had wrought. Prior to fundholding, consultants had no need to take much notice of the GP. Consultants managed their waiting-lists as they saw fit and GPs and patients alike had to accept whatever standard of care was on offer, both in terms of the time a patient had to wait and the quality of the treatment provided when they eventually saw the consultant or, more often, one of his team. The GP could only wait alongside the patients who "basically trusted their doctor to do the best for them knowing that they couldn't always do what they would like". In that situation, GP advocacy was almost meaningless. In terms of the care offered by secondary providers, the judgement was that it could often have been better. GPs had no influence whatsoever, "none at all", on the quality of the service, "we just sort of struggled". Another fundholder described the helplessness of the GP as follows: "We had no say over what their care was or who should undertake that care... There was no-one who could ring up the consultant and say

my patient's had a raw deal. In the old days that would have been entirely dismissed, to blame the consultant - you knew better”.

Theoretically, everyone, at least in a given area, was in the same position. The best the GP could do was apply a little extra pressure to move a patient up the list a bit if she or he judged that the need was particularly urgent. But the effectiveness of this approach often depended on how well the GP had cultivated the local consultants. Thus, sending the proverbial Christmas card was recognised as good practice on the GPs part. A GP described how personal contacts would be used in order to push their particular patient ahead of others. "I ring the consultant and that deals with it". The friendship network, often established in medical school, could also be utilised: "I want you to go and see an old mate of mine in [another part of the country]". In those situations patients knew their GP had "tweaked" the system on their behalf, they were accordingly grateful and appreciative.

The reality of that traditional situation showed up the notion of equal shares as something of a delusion. One GP described the old system as "the doctor who shouted loudest got the money" the fancy "XY machine to do something or the other" even though he knew that left no funding for chiropodists. Another described two other traditional models for allocating resources in the pre-reform NHS: either the lions share went to the middle class articulate patients who knew how to make their voices heard, thus leaving little for the poor

and ill-educated, or there was the "its available for everyone until the money runs out after that nobody gets anything" approach. This latter was the closest the system came to equal shares.

Prior to fundholding, GPs had little choice but to accept all these inequalities for their patients. Interestingly, a reluctant fundholder spoke fondly of the good old days when he could with just a telephone call arrange for a patient to be seen by a specialist in any part of the country, no matter how far away. Now as a fundholder he was restricted to sending his patients to those providers from whom the Practice had contracted to purchase services. Significantly, he saw this as undermining his clinical autonomy.

In the opinion of most fundholders (7 of the 10) the obsequious cultivating of the local consultants or telephone calls to distant mates, what one GP called "the old boy network", had a very limited effect. The new arrangement had changed that situation for the better. Now the Practices could set down in a contract the standards of good practice, as "written down in all the journals"; they expected the consultant to offer to all their patients. Consultants, the Mr Bloggs as one GP called them, were no longer free to run the system as they saw fit; offering idiosyncratic care or allowing waiting lists to grow while they looked after their private Practices. "I personally didn't see why Mr Bloggs should benefit financially from a long waiting list when there were things which told me that Mr Bloggs

could pull his finger out a bit more at the NHS hospital. Then his waiting lists might come down by running a more efficient service”.

On the other hand, fundholders themselves were not impervious to the negative effects their new powers could have on long-term relationships. They knew, or were soon reminded of, the wisdom of not rocking the boat too much. This approach raised a number of ethical questions that did not seem to have figured in the decision-making although each decision was always justified as in the best interests of their patients. Setting their decisions in a wider context it became apparent that, once again, issues beyond considering the best interests of patients were involved.

The freedom to buy better care was, according to all the fundholders, a prime motivation for pursuing fundholding and the poor or poorer quality of some of the local services was mentioned by several interviewees. In the core interview, the Practice found it was in a position to provide better secondary care for its patients by purchasing from outside its area. However, they decided not to offer patients the better service because that would require travelling further afield. "We didn't feel that we wanted to move patients around horrendously"(16).

Yet, this justification does not stand up to scrutiny. The Practice's patients had always been routinely required to travel "horrendous" distances for any number of treatments. Thus, most serious cardiac surgery and certain cancer treatments were, and are,

routinely provided in centres situated up to a hundred miles from patients' homes. In the most rural locations even basic secondary care services required a journey of twenty or thirty miles.

It was noticeable that the fundholders *least willing to challenge their local service provider* were those closest to the hub of the small, close-knit medical community centred in the county town of a mainly rural area. Those doctors might easily meet their hospital based colleagues, such as consultants socially, so "good working relations" were particularly important. Thus, one GP, from a Practice in the centre of the main town in which the general hospital was located, spoke of the Practice's decision to support their local service provider even though the service offered was so poor that it was "to the detriment of patients".

Conversely, fundholders with Practices set well away from the centre seemed far more ready to throw down the gauntlet and demand better secondary services even if this meant asking patients to travel further afield or using the private sector. They had no hesitation in threatening to withdraw their business from local but poor quality providers: "We've got the money now, they have to listen to us".

Another Practice outside the hub of the county's medical community made it quite clear that although "in principle we'd like to support local NHS Trusts", if the private sector offered cheaper but equally good care there would be no objection to using it. In this

context, a fundholder made an interesting observation: "We're an independent Practice - GPs themselves are the private sector".

However, for one two-partner Practice, fundholding was not about exercising power over consultants, "we're too small", but it was about increased control over the way the Practice itself was run. It was an opportunity to revise, rebuild, and strengthen the internal structures so that they would stand up to outside scrutiny

Ethics of Management

Any suggestion that fundholding was unethical and inimical to the values of the NHS and good practice was firmly rejected by the majority of the fundholders I interviewed. Fundholding had taught the value of first-class management and the NHS needed just such management if it was to provide good patient care. Lack of "any recognisable management structure" was identified by one GP as the fundamental weakness not only of his Practice but of the NHS as a whole. Effective management allowed you "to know where you were, know where you were going, know how to get there and be able to do it".

Thus, the suggestion that patients would be better served if resources were taken from management and spent on direct patient care showed a misunderstanding of the place of good management to the service. Far from improving the service, reducing spending on management would take the service back to the position where it

didn't know what it was doing or who was spending what and where. "A publicly funded health care system, because it's so short of money, has to be, to my mind, managed in a first-class way" was how the core interviewee saw the situation.

To another of the GPs, the days of open ended budgets were a thing of the past. "Managing within budget is going to be the norm - not just fundholding but everything". He described this emphasis on effective management as "an ethic that has not pervaded a lot of the health service until recently". In his view, the new ethics was a change for the better. Without it, the NHS could not survive.

For fundholding GPs it seemed that a more overt acceptance of the utilitarian ethics of the common good, already noted in this study as a core value of health care management, had replaced the traditional professional emphasis on the primacy of the individual patient.

Non-Fundholders

Did the approach and attitude of the four non-fundholders I interviewed contrast with that of the fundholders? Did those who rejected fundholding do so because their practice was guided by the principles of modern medical ethics; principles lacking from the decision making of their fundholding colleagues?

Whilst those opposed to fundholding were more inclined to express their opposition in moral terms describing fundholding as unethical, immoral, and wrong; nevertheless as they discussed the

factors that actually played the greatest part in their own decision, just as in the case of their fundholding colleagues, the issues they raised were directly linked not so much to the principles of medical ethics but the ethos of the medical profession as it translated into the experience of the GP. The interviews with the four non-fundholders showed that whilst direct references to ethics was more prominent among this group, the factors that most influenced their decisions were those allied to the profession's ethos. The emphasis on stability, and a disinclination to upset the established order of things, is another aspect of the profession's sense of its own dignity and status.

Influence of partners

Like their fundholding colleagues, the non-fundholders decision had also been a joint venture. Here again, however, the impression I gained from the interviewees, particularly from the strength of feeling with which they spoke, was that each of them seemed to have been the dominant voice influencing the course taken by the Practice as a whole. One partner described the decision-making process: there had been some division between partners but once a majority view became clear no dissent or argument was expected or encouraged. Furthermore, although each year presented the opportunity to enter the fundholding scheme, none of the four non-holders I interviewed made a practice of raising the issue on an annual basis. The subject had been aired, the decision made and,

unless circumstances changed dramatically, it was not considered necessary to discuss it again.

Influence of Political Climate

National

Even the most determined non-fundholders admitted that they would become fundholders if the political climate made it impossible to stay out of the scheme. Three of those I interviewed made the point that there was a feeling that, as fundholding was the government's preferred option, in time, steps would be taken to pressurise non-fundholders into the scheme by slowly starving them of resources. Despite this commonly expressed view, those who had held out against fundholding did not think they had suffered any lack of resources.

Local

Non-fundholders wanted to leave the HA in charge of *negotiating with service providers*. This was, in their view, a morally superior position to that taken by fundholders. The consensus was that the HA had done a reasonable job and non-fundholders were happy to work within that arrangement. Only the HA was in a position to know the *health care needs of the whole community* and to make funding decisions accordingly. While each Practice, whether fundholding or non-fundholding, could only know in detail the needs of their particular patient population at least the non-fundholders

were, in their own view, concerned for that wider community. Fundholders, on the other hand, only looked at the needs within their own particular Practices.

One of the non-fundholders made the point very graphically. In his view under the control of the HA, savings made in one area would be used to meet a need somewhere else in the community. Fundholding had broken up that system by allowing fundholders to keep within the Practice any savings made. Then they were free to spend them on something as trivial “stapling some fat women’s stomach while one of my patients can’t have his hip replacement and is in agony”. That, in his view, was morally reprehensible.

Influence of Managing the Budget

One non-fundholder drew a distinction between the two partners in the Practice who had objected to fundholding on “ethical grounds”, seeing the whole scheme as inherently ‘wrong’, and the remaining three partners, the majority, who had been opposed on grounds of the time managing the fund would take up. This latter objection, however, proved to be a common concern among the non-fundholders. For the majority of partners it was a significant factor in their decision not to take up fundholding and some saw it as an ethical issue. They were “daunted” by the administrative task involved. One made it his first objection to fundholding, referring to “the burden of administrative and managerial tasks”. A third spoke

of the doctors “vocational ethics” being “for patient care not running a business”. Fundholding required that time be given over to managing the budget and this would diminish the care that could be given to their patients.

How fundholders made and used savings from their budget was the issue raised by all the non-fundholders I interviewed. They saw fundholders using funds to add value to partners holdings by refurbishing their buildings instead of putting any savings back into the general pot for the good of all patients in the area. In their assessment, those who had pursued fundholding were mainly motivated, not by concern for their patients, but, by personal greed. One influential non-fundholder claimed that fundholders were “laundering” resources and feathering their own nests.

Money provided for primary care should not, in the view of all the non-fundholders, be held by individual Practices. Rather savings should be a common resource and any used to improve care for the generality of patients, not “tarting up” Practice premises. This point links to the concerns expressed by one of the other non-fundholders regarding the value of staying under the control of HAs.

Even when fundholders used savings to purchase “new services” for their patients these were dismissed by the non-fundholders as merely “cosmetic” and of no real value to patients. To use funds to buy in a counselling service was as much a misuse of funds as using the money to improve partners buildings. In the opinion of the non-

fundholders the whole issue of savings raised “an ethical dilemma” that fundholders were reluctant to address.

Influence of Patients

The paternalistic ethics was as much in evidence among non-fundholders. Like their fundholding colleagues, none of the non-fundholders had consulted their patients about the fundholding decision. Although one Practice had surveyed its patients on the question of whether or not to move to an appointment system⁴⁷ it had not considered using a similar approach when deciding on the fundholding issue.

All four non-fundholders were convinced that the principles of fundholding undermined good patient care. It broke the trust patients had in their doctor. According to one non-fundholder, the reason why patients of fundholders were more demanding, was because “they feel you are not giving them what they want because you want to save money. Whereas we don't have that, I mean it is something that comes between you and the patient whereas with us, money doesn't come into it”.

On the other hand, they also objected to fundholding because it encouraged “the participants to purchase short term advantages for

⁴⁷ Most Practices with more than one partner nowadays operate an appointment system, patients telephone and make an appointment to see a doctor. This Practice, however, maintained the old system where patients simply turned up and waited to be seen and the doctors would work through their waiting room.

their patients at a very, very [original emphasis] local level” without consideration of the needs of the wider local patient community.

Another non-fundholder spoke in terms of the GPs role as advocate: "I don't see myself in the business of rationing. I don't see how you can on the one hand, be a patient's advocate and on the other hand say you can't have that". But then, the same GP took great exception to fundholders because they advocated too strongly on behalf of their patients: "It's morally wrong to grab the best for your own patients...If your patients get more, then somebody else's patients get less and it seems to me that it's all about equal shares, everyone getting a bite of the cherry”.

Among the four non-fundholders there was some difference of opinion as to the extent of any negative impact of fundholding on their own patients. One was quite definite in his view that his patients had not suffered to any real extent by the Practice maintaining its non-fundholding position. Health care outcomes were not better for patients of fundholders compared to those of non-fundholders. However, two of the others saw the situation very differently. Thus, from one: “Our patients were being greatly disadvantaged”. And from the other “It was obviously a two-tier system”. In both instances, the partners had chosen to join the developing commissioning groups, becoming members of the National Association of Commissioning General practitioners and this they felt, had given them new powers in dealing with secondary

care providers. Thus, their patients were no longer in a disadvantaged position.

The impact of fundholding on direct patient care had clearly stirred up a hornets' nest but as can be seen from the views quoted, much of the opposition was expressed in muddled and somewhat contradictory terms.

Influence of Relationship with Other Professionals

Non-fundholders objected very strongly to the attitude of fundholders toward local hospital trusts and the Health Authority. One spoke with great anger of the bullying tactics fundholders employed when negotiating with service providers; threatening the hospital with losing the business of fundholding Practices' if it did not come up with deals for cheaper secondary care. It was particularly distressing to non-fundholders to see the hard-nosed negotiators driving around in "fancy new cars". The motive for pushing down prices was assessed as purely selfish.

The non-fundholders were even more distressed by the fundholders approach to professional colleagues. It was described as "essentially competitive" setting doctor against doctor, GP against GP in a "very confrontational way". There were, according to another interviewee, "big differences in the approach" of the two groups. Not least in the relationship between GP and consultant. Non-fundholders found it very difficult to come to terms with this

aspect of fundholding. Consultants were being directly employed by GPs to provide services to patients in the surgery. Although the arrangement was 'more convenient' for patients and "patients like to have a cosy chat with a consultant in the surgery", this was dismissed as offering only "cosmetic benefits" to the patients concerned.

The important issue to the GP, was that it undermined the traditional way of providing health care, giving an unfair advantage to some patients and extra money in the pockets for the consultants. One non-fundholder summed up her response to the situation as follows: "I feel it would be better if everybody worked under the same rules and, of course, you do your best for your patients within those rules". Operating within those established rules allowed her "if I've got a problem" to "ring the consultant and that deals with it". However, she also recognised that GPs "who haven't been here so long can't use that route". Such inequalities were disappointing but had to be accepted as part of playing by the rules

Nevertheless, despite all their reservations, the non-fundholder had come to see that "not everything about fundholding has been bad in every case". One acknowledged that some of the doctors were "very committed" to the care of their patients and that there had been instances of "good innovations" by fundholders. Beyond that, another accepted that the old system within which he still operated was inefficient.

Even concerns about the relationship between community and hospital had modified over time to the point where three of the four non-fundholders interviewed, agreed that fundholding had changed things for the better across the whole primary care community. All Practices had benefited from the more aggressive stance taken by fundholders: "The hospital certainly listens to what we [non-fundholders] say now, how we want to manage things". "Consultants have had to work harder and more efficiently".

Ethics of Management

In the view of all four non-fundholders, the fundholders excessive cost-awareness had a major and a negative impact on the doctor-patient relationship. Non-fundholders asserted that they alone were standing firm on behalf of patients best interests; providing care without considerations of cost and profit. They pointed an accusing finger at fundholding colleagues portraying their cost awareness in the most negative terms, while at the same time presenting as virtuous their own refusal to take any responsibility for, or account of, the costs their treatment decisions incurred, although they knew full well that somewhere along the line, someone had to take account of those costs. Only one of the non-fundholders was prepared to acknowledge that fact. "I'm not a fundholder, I push for all eight people to get their hips, do or die, and someone else's bill is going to have to do it. That's the sort of comfortable ethical

position...there's a sort of comfort in...not having to take those sort of decisions...the decision will then be taken by someone else”.

This was a view common to all non-fundholders, to the extent that everyone of them used the example of hip replacement to make their argument. “We’ve got patients waiting for hip replacements...I never choose who’s deserving and who isn’t. I just do the best for each person who comes through the door”. When I mentioned the fundholders argument that someone somewhere has to make the difficult choice, one of the non-fundholders simply said: “I’m just not particularly good at that sort of thing and so I don't particularly want to do it”.

However, the non-fundholders opposition revealed some confusion around their basic ethical position. On the one hand, as above, they saw themselves as upholding the traditional medical ethics of the primacy of the patient against the “unethical” fundholders who took account of costs when considering the needs of individual patients. But then they themselves appeared to adopt a utilitarian stance by contrasting their own position - “The GPs job is to look after the whole community not just the individual patient” - with that of fundholding colleagues who used their resources to meet the needs of their own patients without considering the needs of the wider patient population. “We’re not here just to look after our own 6000 patients. We have to remember the 35,000 patients in this area”. Management principles appeared to have moved all

involved in providing health care toward a more overt utilitarian position.

Summary

The hypothesis presented in this thesis contends that, behind the overt acceptance of the principles of modern medical ethics, the medical profession endorses and applies a set of principles and values arising from, and informed by its underlying moral sentiments, its ethos. These focus around professional status. Thus, autonomy, both for the individual practitioner and the profession as a whole, along with a paternalistic attitude toward patients, have for long been key principles in the profession's implicit ethics of practice. The theory would lead us to expect to see these values, rather than those of modern medical ethics, exerting the strongest influence on the thinking of GPs as they contemplated the fundholding option. The interview data confirms that expectation.

Fundholding roused strong feelings in the whole medical community. None of the GPs I interviewed were neutral in their views on the matter. Some spoke of pragmatism; some spoke of conviction; but all spoke with passion.

One partner in a Practice that had very reluctantly indeed opted for fundholding, talked with great feeling about the changes *fundholding* had wrought. The convivial, collegiate nature of former practice was gone; now everyone, including patients, had moved into what he called "contract mode", where the emphasis was on getting

the most for yourself at least cost, no matter what burdens it placed on others. Despite all the reservations, including the "feeling inside that what we were doing was not right" pragmatism dictated that the Practice became fundholders. Once that decision was made there was no point in dwelling on the rights and wrongs, flagellating oneself or wearing a hair shirt; the pragmatic approach was to accept the new situation and get on with the job. Having said that, however, the GP admitted that if he could find another job that paid the same money he would "take it tomorrow".

This despair was exceptional. It was countered by an equally powerful expression of approval from a fundholder, the youngest of the male GPs, who had entered into the new arrangement with great enthusiasm. He spoke of his surgery as a prison, "we even have bars" he said, pointing to the windows of his ground-floor consulting room. In this prison he was isolated from the outside world for hours every day. In his experience, fundholding had opened the prison, introduced new ideas; fresh ways of dealing not only with the business side of the Practice, but even the way the Practice provided its general medical services. This had been liberating and even though he saw more changes on the horizon, and not all of them to his liking, he was positive and enthusiastic about the future.

Most of the GPs sat between these two poles. Fundholding had not been their preferred *modus operandi* but once it was there they recognised it as an opportunity that they could not afford to miss

both for the benefits it would bring to the Practice and to the quality of care; or level of service, they could offer their patients. All were pleased with the outcome of their decision for now they had "clout"; "power"; "control"; "a voice". And some were positively delighted seeing the potential for their influence to spread right into the heart of hospital services, putting consultants in their rightful place as technicians doing a job for the GP, "how and when" the GP wanted it.

Even if all these advantages were eventually lost, or had to be given up, due to the new local or national political pressures, fundholding was still seen to have been worthwhile, not least for the financial and business benefit it had brought to the Practices involved.

Thus, looking back to the core interview, when that Practice first considered becoming fundholders, they did so with the idea that it would probably be for a very limited period; five years was the estimated life-span of their involvement. The decision to pursue this medium term project appeared to have been in some part financial. They would support the scheme for as long as they could make savings but once the budget was tightened up to the point where savings were difficult or impossible to find, then it would be time to "drop it".

The Practice was considering entering the fundholding scheme at the very earliest opportunity, as first wavers. According to the

GP, their major concern was to change attitudes so as to deliver long-term improvements in primary care. Yet from the outset improving patient care was not the only consideration in the mind of this and other potential fundholders, they were also focused on the financial benefits to the Practice. Savings were the incentive; no savings, no fundholding (33) (34).

At that very early stage of the whole fundholding scheme, there were no alternatives such as have been devised and developed in recent years (1997-1999). As far as the partners knew “dropping it” would in all probability mean going back to the *status quo* and losing all the benefits that had been gained for their patients. It would also mean losing the new freedoms and increased power that fundholding offered.

On the other hand, fundholding offered the possibility of a permanent, or at least long-term, benefit in the form of value added to the partnership through, for instance, improvements to the building they owned. As a small business run by independent contractors, these factors would of necessity weigh in the decision. Thus, from a business perspective, although “dropping it” would leave GPs themselves with the some loss of power and patients with a lower quality of care this would be outweighed by the long term financial gain to the partnership.

Fundholding had given GPs new opportunities to achieve their "clear and unambiguous survival goal or *primary purpose*... sufficient

fees to pay all of the bills and make enough profit to pay the partners according to their expectations" (Hadley & Foster, 1993, p.140, emphasis added).

However, a natural conservatism surrounds much of medical practice and informs the views of practitioners. Many GPs would, therefore, have found themselves uncomfortable with, even threatened by, this new entrepreneurial spirit. This came through in the interviews as the attitude that informed the thinking of those who rejected the fundholding option. The action of fundholders was described as unethical, but the real resentment was for the way fundholding had turned the whole GP world upside down.

"Divisive" was the one word used by all non-fundholders when describing the fundholding project. Fundholding had upset the established structures and undermined traditional relationships; destabilised the familiar order and called into question long held values and modes of operation. It had thereby forced all doctors to face issues they would rather have left unexamined and to take on responsibilities they were disinclined to accept. Thus, by breaking ranks, fundholders had shown up the flaws in the system and placed all GPs, whether fundholders or not, under a pressure to be more aggressive on behalf of their patients, less servile in their dealings with consultants and the HA, and finally more aware of the cost implications of their treatment decisions. Many would clearly have preferred to continue under the old rules and the "more comfortable

ethical position" that allowed GPs to order treatment, or refer to the secondary sector, without direct consideration of the quality of care on offer or any impact on the resources available.

Many GPs of the old school preferred to continue with the system they had grown up with, "a very static environment", in which they had operated for thirty years or more. A fundholder spoke of the new arrangement as one that called for "a totally different dynamic", and "an attitude that until recently had not pervaded a lot of health care", it had "put the cat among the pigeons". Another fundholder castigated much of traditional medical practice as "a theocracy" characterised by "weird" doctors whose *modus operandi* was "top down paternalistic medicine" and for whom "clinical autonomy was a right they demanded not a privilege they earned". In his view such doctors were a dying breed.

In all the 15 interviews, whether with the 11 fundholders or the 4 non-fundholders, there was an undoubted concern for the care of their patients but it was not the paramount consideration when deciding on the fundholding issue. Relationships with colleagues; establishing or reinforcing status; independence including the freedom to pursue sound business practice; an attachment to the *status quo*; all these stood out, either singly or in combination, as central elements in the decision of the GPs concerned.

The theory propounded and tested in this thesis argues that all of these concerns reflect attitudes, beliefs, and values inherent in the

ethos, the fundamental moral sentiments, of the profession. They are not signs of unethical thinking, but rather are the ethical values arising from and endorsed by that ethos. The relative importance that each Practice, or each GP within the Practice, attached to those key ethos-based values determined whether the Practice took the fundholding or non-fundholding path.

Chapter 9

Discussion

"Why do you have two handkerchiefs, Daddy?"
asked the little daughter.

"Well, this one," replied her father, pointing to the
fine silk item in his breast pocket, "is for show. But
this one," pulling out a crumpled cotton version
from his trouser pocket, "is for blow".

Childhood conversation recalled by a friend

In his study of the ethical climate within a variety of organisations Cullen (1990), concluded that whilst "firms are developing codes of ethics, using moral character as a selection criterion, monitoring the ethical judgements of managers, and training managers in ethical decision making" (p.93), it was the underlying moral climate within an organisation, that which I have identified in this thesis as the ethos, that most often determined the type of decisions made. This results in a very different set of operating values. In other words, although a firm will in its code of conduct; its formal explicit ethics, espouse one type of behaviour, the ethos of the organisation; its moral atmosphere, may well produce a markedly different outcome in the everyday implicit ethics of practice.

That moral atmosphere is created by those who have influence within the organisation. Yeager (1990), found that "managers' perceptions of the behaviors (*sic*) or beliefs of significant others in their organization (*sic*) were predictive of the managers' own tendency to commit unethical acts [such] as concealing errors". Jackall in his study of the "moral terrain" of management in America

summed it up thus: “morality in the corporation is what the guy above you wants from you” (1986, p.6).

Valance (1995), identified a recent trend by organisations and companies to formulate codes of ethical practice. She assessed the reason for this move as an attempt to restore confidence following adverse reaction from the public to various business scandals of the late 1980s. In her view, “ethical commitment can be a central part of the business vision” and “an overt ethical position” has become “a strategic imperative” giving to the business “a direct competitive edge” (p.184). Business and management are learning what professions such as medicine have known for a long time, namely, the importance of a formal, explicit statement of ethical policy.

But the overt ethical position is only one element in the behaviour of professionals. What Cullen, Yeager, Jackall and others have recently observed within the world of business and management has, again, long been the case within the professions. While the overt statements of ethics meets the public ideal of professional conduct, the everyday behaviour, the implicit ethics of practice, is informed by the ethos of the profession. Furthermore, the influence of the ethos is felt differently by different groups within the profession.

Management and the Medical Ethos

In his study of medical talk Atkinson (1998), identified not one medical voice but different voices within the one medical domain.

He noted that this “raised the intriguing possibility that those different voices might themselves be in conflict”. That conflict, he suggested arose from their “contrasting orientations to medical work...and modalities of medical knowledge” (p.137). Those contrasting orientations will also affect the way different sections respond to the influence of the profession’s ethos.

The voice heard in the interviews is the voice of the GP. It is not always a united voice. Arising as it does, however, from the GPs own orientation to medical work and modality of knowledge, it is a voice distinctly different from that of the hospital-based doctor, particularly the elite consultant group. Despite the widespread opposition of the profession, including the representatives of general practice to fundholding, that distinct perspective led many GPs to take a different view. A significant number took up the fundholding option to the extent that by the end of the scheme half the patient population was registered with fundholding Practices. The motivation for both those who took up the option and those who rejected it, was to protect values absorbed from the profession’s ethos but applied by GPs to their distinctly different working situation.

The medical ethos, the profession’s distinctive sense of its own nobility and finely developed awareness of its importance and value, has provided the foundation for all its thinking and actions. It has for long been the moral backdrop for both the profession as a whole

and its individual practitioners. However, as this study has shown, that ethos of nobility lead certain “elite” branches of the profession to look with some disdain on their general practice colleagues. These, in turn, having themselves absorbed that ethos, on the one hand felt keenly the lack of respect and prestige hospital-based colleagues accorded their activities and, on the other, focused on and valued their status as independent practitioners. In this context, the decision of GPs to take up the fundholding option was as much of a piece with the values informed by the profession’s ethos as was the decision of those who rejected the option.

The decision on whether or not to become fundholders depended, as in the case of 19th century GPs facing change, on how each Practice balanced the “in-built conservatism that tended to preserve the *status quo*” against responding to “changing professional opportunities by achieving stronger Practice organization (*sic*), exploiting new technologies, or adopting more effective time management” (Digby, 1999, p.126).

The GPs in their Practices, those small, independent businesses, ‘the private sector at the heart of the NHS’, acted according to how each thought their independence would be best protected and their status enhanced. Some saw advantage in having management responsibility for their own budgets, controlling costs of care provided to patients by use of contracts and the like, with the opportunity to make savings and even enhance the value of the

Practice. Even the most reluctant fundholders found that having their hands ‘on the money’ changed their whole situation. It gave them a voice, and real control.

Others eschewed such direct management preferring the *status quo* of “inherited methods of working” (Digby, 1999, p.126) and so resisted what they saw as the imposition of more red tape, and new forms of outside interference. Thus, the GP, who described with some satisfaction, the practice within which she was a senior partner as “old-fashioned”, did not “particularly want” to spend “hours and hours” deciding how to manage resources. She was much happier with “someone else” taking on that role. From her perspective, protecting the freedom to practice was best achieved by staying outside the fundholding scheme.

Although one of the GPs I interviewed described the management culture as “quite alien to me” he also recognised that it is part of the medical culture for doctors to want to be in control. In his assessment of the profession to which he belonged “doctors have always got this sense of their own self-importance,” and fundholding was welcomed by many because it gave them a new control, namely, direct control over the money. Many of them took to this additional responsibility like the proverbial duck to water. “A lot of us have moved into that world and there are a lot of fundholders who think it is their right to decide these things and feed their egos”.

That rather cynical view was a minority opinion. Many of those interviewed thought it essential not only for the well-being of their own Practice but also for the well-being of the whole NHS that all whose decisions had a cost implication should apply the principles of good management to their decision-making. To be unaware of those costs or to refuse to take responsibility for them was the unethical position.

Thus, the interview data in conjunction with the broader analysis presented in the earlier chapters of this study supports the conclusion that business and management values do not sit uncomfortably within the ethos of medicine and the conduct sanctioned by that ethos. From the time the provision of medical care became a commodity to be bought and sold its practitioners have been at “home in the world of status and money”, to quote one of the fundholders I interviewed. For long years doctors not able to turn their Practices into successful businesses went out of business. The same rules applied to medical practice as to businesses in general (Digby, 1994,1999). Even under the NHS that same business orientation is still evident among doctors in general and GPs in particular. The latter “had always seen themselves as small shopkeepers, running their own business, with a keen sense of how to wring the most money out of the Government” (Klein, 1995, p.200).

The interview material showed up two opposing points of view, two voices within the GP group. Both, however, were informed by

the values of the medical ethos. The opposition of each group to the position of the other was based on their different perceptions of how best to protect their professional interests.

Beyond GPs, the wider profession had its own response to the management reforms. Analysing the historical data shows that while there were expressions of concern for the welfare of patients the real clash was with values arising from the profession's ethos rather than objections arising from the principles of modern medical ethics.

A clash of ethos'

The historical accounts show that the profession's Royal Colleges, its leaders, objected to having the new structures imposed on them from outside. Long used to sitting at the top table, being at the heart of national decision-making in matters relating to health, for the profession to find itself marginalised at such a significant time in the development of the NHS was deeply distressing. It was not used to being treated in such a way.

The leaders of the profession expected to be consulted by government ministers and to advise on the appropriate action. As Professor George Alberti, President of The Royal College of Physicians, noted in an interview he gave to the editor of *The Lancet*: "We talk to government... When government listens it's quite useful" (cf. Lee-Potter, 1997, p.113; Klein, 199, p.185ff). In similar vein Sir Alexander Macara, Chairman of the BMA, described the regular meetings he had with the Secretary of State where, over a rather

good lunch, this section of the profession could raise issues of concern. Until the reforms of the 1980s ministers “had tickled the doctors” (Timmins, 1996, p.414) by respecting these usual channels of communication. However, in the case of these widespread reforms, government broke with this traditional approach. Announcements were made unilaterally and the profession reacted with fury. In order to protect its long-term interests it had to raise objections.

At the local level doctors objected to being managed. I have already noted the speaker who candidly admitted at the aforementioned BAMM conference “doctors are not good team members unless they are leading the team”. Allen (1997a) found widespread dissatisfaction among all grades of doctors with the new management which they saw as “aggressive and intrusive”. They “expressed hostility to the increasing demands made on them by managers with clipboards” (p. 7f).

Yet it has been noted that when doctors themselves take on a direct management role, the attitudes inherent in the medical mindset “translate into an authoritative style” and a scepticism about the value of so-called “people skills” such as good communication (Hadley & Forster, 1993, pp.162,14,15). There is thus, on the one hand, an arrogance that balks at any external management of the doctors’ own practice and, on the other hand, an autocratic style when it comes to doctors themselves exercising management

responsibilities. These attitudes are consistent with the overall medical ethos.

Hospital doctors also found it difficult to cope with what they saw as a lack of respect on the part of managers toward the consultants. One junior doctor commented with some dismay on the changed attitude toward consultants “they’re becoming more and more used like technical monkeys by hospital managers” (Allen, 1997a, p.7). This comment reflected an observation by one of the fundholders I interviewed but with one significant difference: the GP spoke with considerable approval of the changed attitude toward consultants. No longer deferred to, consultants were rightly, in his opinion, increasingly seen by GPs - now in position to ‘call the shots’ - as no more than technicians.

This contrasting view reflects the long-established divide between hospital and community based doctors. Whereas the junior hospital doctor would hope in time to become a consultant with all the status and respect that position traditionally merited, the GP had no such ambitions, instead viewing the prestige expected by and given to consultants as out of proportion to the contribution this overly-revered group made to the care of patients.

Those differences aside, the views expressed by the junior doctors add weight to the argument that the negative attitude the profession expressed towards management was not based so much on widely accepted ethical concerns but rather arose from the ethos

of the profession which holds its traditional elevated status and autonomy very dear. Unsurprising, therefore, that its senior members, the consultants, did not take kindly to being asked by lay managers to account for their actions.

Digby (1999, p.95), observed another aspect of the medical ethos resulting in a contradictory attitude toward “business sentiments”. Within the ethos of the profession “elevated medical ideals were seen as respectable aims, but mercenary realities as shameful, even dishonourable objectives”. Thus, direct involvement with management went against the grain. The profession’s inclination was to present itself as above those matters commonly associated with the new management such as the so-called “bottom line” of money and profit. This concern was reflected in the comments of the *non-fundholders* interviewed for this study. One spoke of the breakdown of trust when cash entered “the doctor patient nexus” and the patient knew that their doctor was keeping an eye on costs. Another believed that patients were going into “contract” mode and demanding more and more because they thought the doctor wasn’t giving them the best treatment, just the cheapest.

Doctors may have for long been involved in behind the scenes and covert management of resources (Harrison, 1988), but for the profession to accept changes requiring doctors to be seen openly considering the cost of a treatment alongside, if not before, the clinical need, undermined an important element of the medical myth,

namely that medicine was practised without any link to financial consideration, to money (Klein, 1995, p.195). For that reason overt involvement in management was anathema. Having over the years skilfully built up a high degree of public confidence and support focused around its oft-stated ethical principle of the primacy of the patient, the profession would be understandably cautious about endorsing any change that might jeopardise that patient trust so vital to the profession's own well-being (Harrison *et al*, 1992, p.102).

The profession well understands that:

As long as doctors retain the respect...loyalty...and...
deference...of the public they will continue to possess
considerable power to contain countervailing forces [such a
pressure from the new managers] and to redirect them or divert
their impact (Hunter, 1992, p.565).

Nevertheless, whilst it may have thought it expedient to hide them from public view, business sentiments have always been important to the profession. Thus, once the reforms were in operation the profession recognised that to “protect and even further its own interests” it had no choice but to embrace the arrangements and become openly involved in the new management (Harrison *et al*, 1992, p.104). Far from demonstrating a rejection of fundamental professional values, this pragmatic decision was wholly in keeping with the established ethos of their profession. It was the justification offered by some fundholders for their decision. Hunter quotes the reason many hospital doctors give for entering management:

“Doctors must play a bigger part in managing the health service in order to protect their clinical freedom”. He goes on to observe that doctors came to appreciate that if they continued to hold back from taking on management roles:

it would not be long before the medical profession suffered loss of status and control over the system...Doctors as managers, then, become a stratagem for ensuring that no fundamental challenge is posed to their prevailing view of the world...far from being shaped by the new managerialism doctors will, as they become more involved in management, shape the management agenda (Hunter, 1992, pp.559,565).

One ethos, two ethics?

Medicine is seen as an ethically based profession with doctors bound by and to a particular set of ethical values. As Ruddick (1998) points out, traditional medical oaths and codes typically portray ideal physicians as devoted to the welfare of patients, responding compassionately to the suffering of patients, humbly mindful of the limits of their curative powers and the harms they may unintentionally cause. The Hippocratic injunction "Strive to help, but above all, do no harm" is the ruling maxim. Restated as beneficence and non-maleficence, it sits along with autonomy and distributive justice to form the elements that now comprise the canonical principles of modern medical ethics to which I have drawn attention throughout this study.

In the GMC's own guidance to doctors the opening statement tells them that "the care of your patients is your first duty". In all the interviews I conducted with GPs, both fund- and non-fundholding, the interviewees showed an underlying concern for the care of their patients, apparently reflecting the doctors' primary duty and suggesting a core ethical principle guiding their thinking. But "patient care" is, as Allmark (1995) points out, no more than ethically neutral. What makes care "good", what gives it an ethical dimension, is when that care is expressed in the right way (cf. Rhodes, 1995, pp.444-5).

This is not to deny that persons may, indeed have often, become doctors for well understood and widely acknowledged ethical reasons, but the care of patients in itself does not make medicine or the practitioner ethical. Notwithstanding the GPs genuine expressions of care for their patients, the data from the interviews I conducted showed other concerns were just as, if not more, important as they contemplated the fundholding option.

The interview data confirmed that which was evident from the historical record. Alongside, some would suggest ahead of, concern for patients, the profession has always had a concern for its own interests, including its place in whatever market it has had to operate. Thus, responding to her own question "did medicine have ethical components which differentiated it from other occupations?" Digby answers: "Rather than being concerned with safeguarding vulnerable

patients the thrust of the principal Georgian professional discussion of ethics was revealingly about regulating 'trade' within a bustling medical market" (Digby, 1994, p.59). These same attitudes governed the profession's response to the creation of the NHS and, some four decades later, its reform. They also governed the thinking of the individual GPs as they decided whether or not to take up fundholding.

The idea that doctors thought, or think, along such, apparently, self-serving lines or make judgements based on such considerations might surprise, and even shock, those outside the profession. But that reaction is due to a lack of understanding of the ethos of the medical profession, and particularly the very specific concerns and interests of the small business general practitioner. Such a misunderstanding is, however, unsurprising. There is a reluctance to accept this aspect of the medical profession's thinking. The preferred image, in both the professional and lay world, is of practice based on what Shock calls "the ancient virtues distilled over time" (Shock, 1994; Allen, 1997, p.3)⁴⁸ above considerations of self-interest (cf. Loudon, 1986, p.272ff).

⁴⁸ This effort to set medical values within an ancient tradition is reminiscent of the words used by the physicians in the 19th century defending their supremacy over their professional colleagues, the surgeons and apothecaries. They described the established structure as "the ancient, the true, the English arrangement". (quoted by Loudon, 1986, p.190)

Doctors inhabit a very distinct world with its own highly developed ethos that produces a distinctive and characteristic way of thinking around ethical issues. Through historical data the thesis has traced the development of this ethos as the profession established itself in the elite society of earlier centuries. Where once the values and ideals that both inform and arise from that ethos would have been widely accepted and understood, today they appear to find little resonance in the community the modern medical profession is expected to serve. Thus, whilst doctors and non-doctors seem to be talking about the same thing when they use the language of modern medical ethics they are not, in fact, sharing a common language at all. Each party is viewing the subject from within their very different frameworks, speaking from their own agenda, one that conforms to their ethos and habit of mind. What to the common mind, or “normal perception” looks callous, indifferent, and unethical, to the medical mind constitutes the properly detached, professional approach. Or that which is perceived by the lay person as “a cover-up” will, within the profession, be understood as due loyalty owed by colleagues who alone understand the pressures born by fellow practitioners.

The medical ethos and the conduct it sanctions has been developing over centuries; the modern principalist medical ethics, on the other hand and notwithstanding its elements of ancient wisdom in the Hippocratic injunction, has only been developed in the latter half

of this century. Prior to the 1960s, such as concepts as informed consent and patient autonomy had no place in medical decision-making, and very little in the lay mind.

Furthermore, the driving force for the principles of modern medical ethics has come from outside the profession, from patient groups rather than doctors themselves. de Certeau (1984, p.19), argues that when a group has imposed upon it a set of values to which it does not fully subscribe then even while it may appear to be accepting those outside values, the group is in fact “sabotaging” them; reshaping them to fit more closely into its own existing value system. The medical profession’s response to the principalist modern medical ethics imposed on it from the non-medical world (Nicholas, 1999 p.508), has included such sabotaging. It has led to the profession translating the principles of the explicit formal ethics into an ‘implicit ethics of practice’ arising from the values endorsed by its old ethos

Thus, when doctors and patients talk about informed consent, *the patient understands that the doctor will provide and discuss all the information necessary to enable the patient to decide whether to proceed with a proposed procedure.* However, informed consent is interpreted by the doctor through another prism, another habit of thinking, one that considers less than open discussion as a positive good, “in the patients best interests”. A paternalistic perspective that justifies deciding how much information a patient will be given and in

what form it will be passed on. A similar situation arises in the context of the notion of autonomy. Patients may see this as closely allied to the principle of informed consent inasmuch as it accepts the patients right to make decisions regarding their own health care. However, such a notion is at variance with the ethos of the medical profession. Traditionally it has taught practitioners to think of autonomy in terms of clinical freedom rather than patient based decision-making.

Doctors may be told that they must show respect and sensitivity to their patients. And yet these principles cannot easily fit into an environment where any indication of emotion is seen as unprofessional (Davies, 1996a, p.6). Doctors are expected by their peers and superiors to display a certain professional distance when dealing with what to most people would be profoundly distressing and shocking situations. Thus, informed by its ethos, the profession passes down what it considers professional, and hence, "right" conduct. This will dictate both the practitioner's and the profession's response to ethics imposed from the outside.

Although in some medical schools much work has been done in very recent years to raise awareness of the application of modern medical ethics to medical practice, the focus is on so-called "ethical dilemmas" and as Nicholas has observed:

We are so busy wanting students to be capable of moral reflection that we pay little attention to the values that underlie

the conceptual and social frameworks with which they and we are working (Nicholas, 1999, p.509).

Weatherall (1997, p.11) also points out that medical students are taught virtually no history of their profession. These gaps in the medical education curricula mean not only that medical students have no knowledge of the way the profession as a whole has developed but, more significantly, no understanding of the development of its ethos - its underlying moral character or tone. Without this understanding, there is the danger that young doctors simply become immersed in the world of medicine without recognising the way in which the profession's ethos provide the values that influence their understanding of ethics, their ideas of what constitutes the good and bad of everyday practice, and the resulting dichotomy between the expectations of ethical practice arising from its formal overt codes of ethics and actual practice arising from its ethos.

This dichotomy operates right at the heart of the profession as witnessed in the disciplinary actions of the GMC. A survey undertaken by a consumer organisation led to the conclusion that the GMC's system is not working in the best interests of patients. Thus, it found that only 2.5% of cases (6 out of 264) taken to the GMC resulted in "concrete action being taken against a doctor". According to the researchers: "Again and again we heard the same story, that the GMC appeared to favour doctors over patients". They concluded "there's a lot the GMC needs to do to bring the

quality of its basic customer care up to an acceptable standard”
(*Which On-line*, 1999).

Several years ago Jean Robinson (1988, p.31), as a lay representative on those GMC hearings, expressed her dismay at the difference between the profession’s rhetoric of protecting patients interests reflecting its public stated ethics, and the reality of the GMC’s decisions in dealing with doctors’ misconduct guided by its private ethos. Over a decade later the situation appears not to have changed at all. The rhetoric is the same and so is the rather different practice.

In his study of the profession of medicine Freidson “attempted to evaluate” the profession’s claim to expertise and, what he calls, “ethicity”. He concluded that both claims are illusions (Freidson, 1970, p.377f). Following my research I would not accept that medicine’s claim to ethical practice is an illusion or a mere epiphenomenon. Rather, my focus on the role of the ethos on thinking and practice shows the profession as “differently ethical”. Ethical principles are at the heart of the profession but they are either principles arising directly from the profession’s traditional view of right as informed by its own ethos or, in the case of the four principles of moderns medical ethics, interpreted and applied in light of that ethos. It is this that has led to misunderstanding, disappointment, anger and accusations of unethical conduct. It is

now an approach to which the non-professional world appears increasingly unsympathetic.

A Changing Ethos?

Despite the persistence of the traditional ethos, the profession is under pressure to change. This pressure comes, in large measure, from outside itself in the wider social, cultural, and political environment.⁴⁹ The ethos of the profession reflects a different set of underlying moral values and beliefs to those of the lay community. The myths and values that lie at the heart of the medical ethos, and inform its application of ethical principles, find little resonance outside of the profession. The result is that the profession has come under increasingly severe scrutiny from a public that no longer trusts its ethical instincts. The finely developed sense of professional worth and dignity, the moral atmosphere or ethos, that informs medical thinking and practice, its implicit ethics of practice, no longer connects to the public perceptions of the ethical and is not seen to meet the needs of its client-groups. In this circumstance that ethos and its ethics has no valid justification. Change, albeit reluctant, is unavoidable (Jonas, 1983, p.45; Freidson, 1970, p.350).

The younger doctors interviewed by Allen (1997) also highlighted this changing attitude. They recognised, and even encouraged, from their patients a more questioning, less deferential,

⁴⁹See also editor's comment on public perceptions of the GMC's disciplinary procedures (Smith, 1998)

attitude. Added to that, they showed an increasing awareness of the complexities of modern scientific medicine and of the fact that many of its procedures may do as much harm as good (cf. Lupton, 1994, p.66). In such a changing environment they were less inclined to present themselves as the infallible expert who alone knew what was in the patients' best interests and who must, therefore, be trusted to represent those interest at all times (Allen, 1997, p.5). This was in contrast to the attitude and beliefs of older doctors.

Interviews I conducted confirmed this perception. Several of my respondents spoke of "a totally different attitude" on the part of doctors entering general practice. They saw the old sense of vocation fast disappearing; the patrician doctor dying out and moving toward retirement with young doctors, "totally different animals", bringing a new set of attitudes into the profession. These more closely reflected those prevalent in the wider cross-section of society from which they are drawn. Increasingly these young doctors preferred the security of a salaried service to the traditional GPs emphasis on the sacrosanct independent practitioner, had abandoned the patrician style and were prepared to enter into "a much more balanced dialogue" with their patients. Where older doctors would have classified "clued up" patients as "difficult" the new breed welcomed their involvement and respected their interest and knowledge. However, their different understanding of "vocationalism" meant they were not prepared to accept the

workload that many of their older colleagues took on as a matter routine. Hence they saw nothing wrong in establishing a private life beyond the surgery where patient demands would not be allowed to intrude, for that reason the use of deputising services had become much more widespread.

Allen's research also showed that younger doctors wanted more of a private and social life with their families, something older doctors appeared to equate with a lack of commitment. On the other hand, older doctors were seen by the younger generation of doctors to have a greater interest in private practice, committee membership, and leisure activities and were, therefore, not "as committed to medicine on a daily basis" (Allen, 1997, p.10). It should be noted, in passing, that "commitment" is, according to the leaders of the profession, one of its "core values".

Women now make up a majority of those entering medical school and, despite the difficulties they face in moving up through the profession, their presence in increasing numbers will, albeit gradually, make an impact on the ethos of the profession. Although the two women I interviewed showed no great divergence of views from those expressed by the male interviewees⁵⁰ interview data gathered by other researchers confirms a difference in attitude. Allen

⁵⁰ Though the style of the interview was noticeably different. The women GPs seemed more inclined to engage in a conversation, albeit a directed one, rather than launch into the lengthy 'speeches' that characterised the answers of the male interviewees.

quotes a women consultant who described the difference in style between the patrician male consultant and herself as a women consultant. "I'm there a lot - I'm in my greens."⁵¹ I'll go and kneel down at someone's bed and talk to the relatives and they don't think that's a consultant. But when they see my colleague coming in his pin-stripe suit and his entourage, they think that's a consultant. But on the other hand we get a lot of people saying they're very surprised at how much they've been told. They've been fully informed and involved and even if the outcome is bad, they appreciate that" (Allen, 1997a, p.6). This approach suggests that women are more comfortable with partnership in patient care and as such are unlikely to endorse the "doctors orders" style of medicine practised by their predominantly male predecessors.

Patients too are less willing to give doctors *carte blanche* in decisions affecting their health. Instead they want, expect, and even demand, more openness and greater accountability from the profession. The government, for reasons as much to do with its own changed agenda toward expensive doctor-centred medicine as responsiveness to public opinion, is moving toward closer regulation of the profession.

The Education Committee of the GMC, as discussed above, has called for traditional attitudes within the medical profession to be

⁵¹ The gown and trousers worn in the operating theatre.

replaced by those more appropriate to the changing patterns of patient care. It urged that this should be done “not simply as an expedient but because education should reflect the realities of modern medicine” (para. 45) In offering this “warning” the committee pointed to the danger of changing the rhetoric without addressing what I have identified as the underlying ethos.

All these factors appear to be bringing about a change in the medical ethos. However, many of the changes the profession is prepared to accept seem more designed to protect the ethos and its core values, particularly the freedom of the profession to regulate itself, than to challenge it. Whatever positive change is currently under way, it will take some considerable time for new attitudes to filter through to Jonsen’s “old boys” of medicine who still lead in many areas of the profession. The traditional attitudes fostered by the ethos remain a powerful influence at the highest levels of medical practice

Hunter (2000), argues that despite all the management changes wrought over recent years within the NHS, the old attitudes that characterise the medical profession remain unchanged:

For the most part, doctors continue to see the NHS as a supply of resources which exist for them to access to achieve their professional and personal goals. Managers exist to provide them with these resources, not to challenge their clinical practice (p77).

Furthermore, he is not convinced that the younger generation of doctors will significantly alter this situation. The attitudes that in this thesis I have argued arise from and are reinforced by the old ethos are, in Hunter's opinion, safely entrenched for many years to come. "The stereotype remains very much alive and well" (p.77).

The reported attitude of a consultant appears to confirm this assessment. He was attending an "equal opportunity" training session in November 1998 to encourage fairer job selection and is reported to have given the following reason for attending the session: "I'm not having any f...ing women in my department or any f...ing Indians either. I just want to learn how to break the law" (Hammond & Mosley, 1999, p. 6). Another consultant spoke with dismay of the changing attitudes he detected among patients. "The main psychological blow of the past few years came with the patient's charter. The majority of patients...had regarded NHS health care as a privilege. By and large they accepted the limitations of the service as long as their carers actually cared. Overnight health care became a right. With rights come expectations and intolerance" (Sandmann, 1999).

As Digby noted of another era "it took time for new cohorts to replace those trained earlier in a traditional mould" (Digby, 1994, p.99).

The attitude of doctors toward outside scrutiny of their practice similarly reflects a determination to maintain clinical autonomy. The

experience of the audit manager described earlier in this study shows how ingrained is the profession's adherence to this largely outmoded principle. Practitioners continue actively to resist moves to identify and foster best practice if it means opening up their own mode of practice to question. Among the doctors I interviewed only one had no difficulty accepting, even asking for, outside guidance on prescribing and overall best practice: "If they can suggest a better way, I'm all for it". He was also the doctor who appeared least threatened by knowledgeable patients. Among my small sample his attitude was exceptional and the experience of the audit manager indicates that his views were uncommon in the wider GP population. Two factors may account for this difference. Firstly, his age. He was the youngest of the male doctors. Secondly, he had not been born and brought up in the social strata that has for long provided the majority of medical practitioners. He had not come through the system I have identified as the breeding ground of the values at the heart of the traditional medical ethos.

Wider social changes suggest that over time the exceptions will become the norm as the traditional ethos faces more and more challenges. Enough challenges to make, in due course, a significant impact on ethical conduct in the practice of medicine leading to a convergence between the conduct which the modern principlist medical ethics leads patients to expect and that which doctors actually deliver.

However, if the profession is to feel comfortable with a more open and honest presentation of the range of values that inform medical practice, there must be an equal willingness on the part of patients to take a more mature view of the motives that inspire orthodox medicine and its practitioners. The natural fear of disease and death encourages the mythologising of those who would save us from these “evils”. This blinds us to what George Bernard Shaw observed of “the honour and conscience of doctors”, namely, that “they have as much as any other class of men, no more and no less” (Quoted by Allsop, 1995, p. 331, from Preface to *Doctors Dilemma*). Likewise, doctors are not above the ordinary desires and motivations of the rest of the population. The self-interest that Adam Smith (p.13), identified as the central impulsion for so much human activity is not, and can never be, absent from the modern medical profession. To resist this reality and insist on a mythologised version of medical practice is to encourage the worst aspects of the medical ethos, namely the arrogance and secrecy that have given rise to the judgements and actions now often condemned in the lay world as unethical.

Conclusion

The Research Project

The research began by focusing on the possibility of a conflict between the medical profession and the new public management introduced by government in the late 1980s. The four principles of modern medical ethics suggested the values espoused by the medical profession would be in conflict with the business orientated values underpinning the management reforms. Exploring this apparent conflict brought in to focus a distinction relating to ethics, namely, that between a profession's ethos and its formal explicit code of ethics.

The hypothesis this thesis set out to test is that doctors' decision-making and practice has always been influenced by the ethos, the fundamental moral spirit or atmosphere, permeating the profession. It is from its ethos, the conviction of itself as a noble and superior profession, that the medical profession derives its everyday implicit ethics of practice. Furthermore, the ethical principles and values commonly assumed to guide the medical practitioner, the explicit formal code based around the concept of "patients' best interests" and the "four principles", are interpreted and understood within the profession through that ethos. Thus, their application in medical thinking and practice will not always accord with the understanding those outside the profession have of those principles. This, in turn, can lead to a perception of "unethical" behaviour.

If a profession is obliged, often for reasons of public acceptability, to base its code of ethics on values and beliefs that are out of harmony with its fundamental moral spirit, its ethos, then that code will be adhered to in word but not in deed. In other words, the formal explicit code of ethics will bear only a superficial relationship to the implicit ethics of practice. Understanding the role that ethos plays in the application and interpretation of ethics can make a valuable contribution to our understanding of how a profession sees its formal code and, more importantly, to the construction of future codes of ethics practice.

I began by tracing the relationship of the profession to modern medical ethics. A study of the history of the profession explained why an explicit formal code of ethics became so important to the profession and highlighted the myths that were incorporated into that ethics. At the same time it showed up values and beliefs that predated the ethics and lay at the profession's heart. Arising from, and intimately connected to its ethos were values emphasising the authority of medicine, loyalty, professional autonomy and clinical freedom.

I then sought to explore the impact of that ethos on the profession's thinking and decision-making in major policy areas, as well as in everyday practice. This I did by looking at the response of the profession, firstly to the creation and development of the NHS and then to the management reforms introduced from the mid 1980s

onwards. What values had the greater influence on the profession's response to these major movements in the provision of publicly funded health care? Those directly arising from publicly espoused modern principalist medical ethics or those informed by the profession's ethos? In the case of the introduction of the NHS the question was answered by looking at the historical data. In the later development the focus was particularly on GPs facing the decision of whether or not to take up fundholding responsibilities and the question was answered by analysing data gathered from direct interviewing of GPs.

The historical data showed that whilst a concern for patients was apparent in the medical profession's response to the creation of the NHS, and particularly so in its public pronouncements, behind the scenes, in its negotiations with government the main concern was for the interests of the profession itself. Over the course of those negotiations the opposition of the consultants was bought off but the general practice arm of the profession fought to the end to protect the status of practitioners as independent small business men and women.

Once the service was operating the profession gradually came round to giving it more than mere grudging support. Guided by an ethos that placed the greatest emphasis on professional autonomy, the leadership of the profession sought to set its own hands on the levers that controlled the service. More than that, individual

consultants felt it their right to manipulate as far as they could the system to protect, and wherever possible, enhance their own professional standing. This approach often worked against the best interests of the most vulnerable patients or patient groups.

The 1980 reforms challenged the profession's position of control both at the national and local level. The overall goal of the reforms was to give management more direct control over the NHS whereas at the heart of the medical ethos lies the principle of autonomy, self-regulation. The profession's mixed response to this challenge was analysed by reference to the historical record but also by interviewing a particular group of doctors for whom the challenge offered a very particular choice. This primary and secondary data provided a case study that enabled me to test the theory.

Within the hospital the emphasis on control by general managers clashed directly with the established order in which consultants had the main voice. Within the community, however, were the independent-minded GPs who tended to see themselves as the poor relations in the medical hierarchy, lacking the prestige of the hospital-based doctor. GPs were invited to take on the management of their own practice budget and they were offered a number of incentives to accept the invitation. Not least of these incentives was greater freedom in their own Practice, a greater voice in the standard of secondary services provided by consultants, and the opportunity to use savings from their budget to benefit their Practice, including

refurbishing buildings and updating equipment. In other words, while the reforms were perceived as a threat to the consultants status many GPs saw opportunities for their own status to be enhanced. This presented GPs with a dilemma: on the one hand there were a number of attractive incentives to encourage Practices to take up the option on the other hand, fundholding upset the *status quo* and was met with widespread opposition from fellow professionals and the wider public. The interviews sought to identify the values and beliefs that had the most influence on GPs in making their decision.

The interview data showed that concern for patients did figure in their thinking. But, there were other concerns linked to the traditional values and beliefs of the profession, particularly as they related to the position of the GP, and these carried moral weight in the decision. Overall, the data did not support the notion of an ethical conflict between medicine and management.

Understanding the all-pervading influence and moral force of these other values offered an insight into a real conflict. In relation to the direct care of patients the medical ethos endorses a paternalistic attitude thereby encouraging a very particular view of ethical conduct. That view does not always chime in with the values and principles of the lay world it serves. Thus, concepts such as patients best interests, patient autonomy, and informed consent will often not mean the same to the professional, particularly the older professional, as they do to the lay-person. Offering patients choices,

giving them information, discussing the problematic nature of treatments, and waiting on them to decide is an approach that, within the context of the traditional ethos, is in itself unethical. The doctors trained to think of their role in terms of a wise parent protecting and caring for a sick and vulnerable child will be hard pressed to see it in any other way.

A profession or organisation's ethos creates a form of virtue ethics that I have called the "implicit ethics of practice". However, professions and organisations that have to attract clients or users from the lay community also recognise the need for an explicit ethics that meets the concerns and interests of the lay community. Hence the construction of what constitutes ethics for public consumption. The differences between the two faces of professional ethics creates the potential for conflict. Such conflicts cannot be resolved by merely tightening the regulations governing the profession or organisation. A successful resolution must involve identifying and understanding what is going on behind the scenes in the hinterland of professional ethics, the interplay between the profession's ethos, its 'implicit ethics of practice, and its explicit, formal ethics of public thinking and action.

Strengths

Goldberg (1993, pp.3,4), argues that academics working in the field of professional ethics need to grasp the character and history of the profession under study if they are to make an informed

contribution. The particular strength of this study is that in focusing on the medical ethos, it has drawn attention to an aspect of the medical character and history that has not been given the attention it merits. Although there continues to be considerable and growing interest in identifying and resolving ethical dilemmas, both in the fields of medicine and management, there has been little if any in-depth analysis of the impact of ethos on the construction of an appropriate code of ethics. Yet, as this research has shown, it is from its ethos that a profession or organisation finds its sense of what is right and wrong practice, its everyday implicit ethics of practice as against the formal, explicit ethics of public discussion and action informed by public expectations of ethical practice (Irvine, 2001). Ignoring the influence of ethos on ethics creates misunderstandings between the profession and lay public that ultimately breaks down trust between the two groups. The recent spate of enquiries into established medical practice suggest that such an outcome is increasingly evident.

Furthermore, the research allows us to hear the voice of a particular group of doctors, namely, general practitioners, at a significant and unique moment in their history. Their views on fundholding, their reasons for accepting or rejecting the new scheme, and their experiences of operating within a rapidly changing NHS, offer an valuable insight into the thinking of the GP around an issue that raised fundamental questions regarding the public provision of

health care within the UK. Their experience well illustrated the operation of the medical ethos on the thinking and actions of a particular group of practitioners.

Weaknesses

The project would have greatly benefited from hearing the views from a range of younger doctors. All but one of the GPs I interviewed were in their late forties or older. I would also like to have heard the views of those entering medical school, those responsible for imparting the medical mind to students, and those charged with safeguarding the standards of the profession in the Royal Colleges and the GMC.

Having established a distinct place for ethos I would like to have had the time and space to look in much more detail, at the other factors that work with ethos in order to create a code of ethics. In this study I chose to focus on the one factor that the literature showed to have been largely overlooked. Whilst I have demonstrated that the role of ethos merits far greater recognition, I am fully aware that it is not the only influential factor.

A profession's ethics arise from an interplay of factors. A complex system of influence and counter influence combine to create or interpret a code of ethics. Personal belief systems and public expectations play their part. Two other significant factors are the culture, that is to say "the body of learned behaviors (*sic*) that shape behaviour (*sic*) and consciousness", and ideology, "the local systems

of knowledge embedded in particular institutions” (Lindenbaum & Lock 1993, p.80). It would be an interesting exercise to develop these interconnections but such was not possible within the confines of this thesis. Notwithstanding the importance of recognising this interrelationship, a broader discussion of medical ideology or medical culture would not have drawn out the subtle but essential *moral* element that makes the concept of a medical ethos distinctive and gives it its potency.

These areas of suggested weakness do not seriously undermine the overall argument and the conclusions which I have drawn. Nevertheless, at the end of this project I am all too aware that this has been very much an initial exploration of a field that merits a great deal more work.

Further Research

Having established a background for further research there are several directions in which it could proceed. The next stage that directly links to this project should involve following a cohort of medical students through their training to hear and see first hand the way the profession’s ethos is being assimilated and its impact on their moral reasoning. This group should comprise a representative mix: white, male, middle class, public school, female, working class, and from an ethnic minority group, in order to begin to see what impact social background has on assimilation of the established medical ethos. Interviews would take place at the outset of their training in order to assess the attitude of the group toward elements identified in

this research as characteristic and defining of the traditional medical ethos. Further interviews, with individuals and the group, would occur at significant points throughout the training. The research should also include interviews with class-room lecturers and consultants responsible for on-ward training as well as participant and non-participant observation of a range of learning situations in both formal, such as class room and ward, and informal social settings.

In reporting on her experience at the GMC Robinson offered the observation that “there have been many changes in the profession’s code over the years”. She commented that a study of those changes “would make an interesting PhD thesis” (1988, p.31). I entirely agree but would suggest that setting such a study in the context of the research presented in this thesis, drawing out the contrast between an ethics that has to change in response to the demands of public taste and the long-standing beliefs and values I have identified as characteristic of the profession, in other words its ethos, would make it an even more exciting and worthwhile project.

The relationship between ethos and ethics is also relevant to other health care professions. Thus, the initial research suggests that nursing has much to gain from tracing the development of its ethos and the impact it has had on the nurses code of ethics. This could assist the profession to take its present code beyond what has been seen as sincere but meaningless rhetoric (Edgar, 1994, p.161).

Limentani (1999), notes a move toward a common code of ethics for all health care professionals. The findings of my research strongly suggest that if such a move is to succeed, it will be necessary to begin by clearly identifying the underlying motivating moral spirit and disposition, the ethos, of all the professions involved. Without that understanding, there is the very real possibility that the resulting common code will either be so general as to be meaningless or structured in such a way as to favour the ethos and interests of the dominant profession over those of the other professions, for example medicine over nursing.

Questions raised by Nicholas (1999) on the role of those who teach medical ethics suggest there is room to begin exploring the ethos and ethics of that profession. Medical ethics educators play an important part in helping medical students structure their view of the world. "We contribute to maintaining or transforming the status quo" (pp 507,508) And yet, she notes, the focus of medical ethics education is always on strategies of ethics teaching and an assessment of various methodologies but there is no questioning of the intent of such education: "The **intent** of medical ethics education is generally described in terms acceptable to the medical discourse...Silence on this matter leaves educators open to the accusation that we are agents for indoctrinating students into the norms of medical practice, and are avoiding the difficult questions

about our own position and in the changing and politicised world of medicine” (p.509, bold type original).

What is the underlying character and disposition of this relatively young profession? Is it so anxious to maintain its standing with the “socially powerful participants in health care”, namely, the medical profession, that it is constrained from questioning the fundamentals of how that senior profession provides health care? If the role of the ethicists is seen as no more than that of providing moral justifications for anything and everything the medical profession does or seeks to do then its own credibility is seriously undermined. Seedhouse (1995) has suggested that the symbiotic relationship between medicine and bioethics is too close for bioethics to be of any real value. Analysing the ethos of the profession will help our understanding of the nature of that relationship and how it might be enhanced to the long-term benefit of educators and educated

Outside the field of health care, the work has application in areas of business and private sector management. Research can help companies and organisations understand the import of the relationship between ethos and ethics and incorporate the insights gained from this understanding into their own search for ethical practice. In so doing it may help stem the trend not only toward a highly reductionist but a shallow and ineffective role for ethics in public life that is evident in the traditional yet flawed path of Pincoff’s “quandary ethics” as well as the plethora of “anodyne” and

even “unethical” codes of conduct (Sheaff & West, 1995, p. 203; Pattison, 2001, p.9).

Summary

Long before medical ethics became a curriculum subject, medical students learnt the ethics of their profession from the ethos of their profession. And they still do. The debates and questions about how “medical ethics” should be taught to medical students overlook that significant point. Many of the publicly expressed concerns about unethical practice arise from a misunderstanding of this reality. The ethics that inform and guide medical practice and decision-making, from major to everyday issues, are those which arise out of its ethos - the belief in itself as a noble and superior profession, one of special dignity and worth. This was seen to be the so in the case study material presented in the second part of the study.

Principles and beliefs that do not have their roots in the profession’s ethos will not have the same impact on the everyday world of medicine. No matter how those principles are taught they will remain the ethics for show, to be brought out and deliberated over in formal learning situations or when responding to issues that have become public concern. This is the point at which conflict can arise as the values the profession appears to espouse are perceived to stand at odds with important aspects of actual practice.

However, as the ethos, the pervasive moral atmosphere of the profession, changes so will its everyday and implicit ethics of practice. In every profession and organisation it is ethos, that which comes before, or precedes, its ethics, that should be the focus of questions and debates by those concerned with the ethics of professional thinking and practice. If overt ethical statements or codes are to be more than fine sounding words, the first step must be to identify and understand the particular “moral nature; the characteristic 'spirit' or 'tone'” (Merriam-Websters, 2000), the ethos of the profession.

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Appendix A

Letter sent out to practice managers:

Address for reply
Telephone number
Email

Date

Practice address

Dear *(name or title)*

I am undertaking doctoral research with the Open University into the attitude of general practitioners to fundholding.

As yours is a fundholding/non-fundholding *(one deleted as appropriate)* Practice, I am interested to hear the views of your GPs, and would be most grateful if one (or more) of the Partners could spare some time for an interview.

Should the Partners need more information before deciding whether to grant me an interview, please feel free to contact me.

Yours sincerely,

(signature)

Christine R E H Descombes BA; MA

APPENDIX B

Topic Schedule for Interview with Fundholders

Reassurance of confidentiality and anonymity.

- 1) How long in Practice? Responsibilities relating to fundholding?
- 2) Describe Practice profile? (size and type of population etc.)
- 3) How long FH?
- 4) Why became FH?
- 5) Personal qualms? Practice concerns?
- 6) Significant differences from previous (non-FH) status?
- 7) Benefits? Drawbacks?
- 8) Ethical dilemmas? Define, describe. How resolved?
- 9) Constraints? Impact on own practice?
- 10) Relationship between values of managing budget and those relating to professional practice?

APPENDIX C

INTERVIEW SCHEDULE FOR NON-FH

- 1) How long in practice?
- 2) Practice profile
- 3) Re. FH. Views within partnership. Any benefits. Basis for deciding against FH.
- 4) Impact on patients of decision not to become FH.
- 5) Relationship with FHs.
- 6) Circumstances that would lead to reconsidering decision.

APPENDIX D

GP Practice Profiles

Ten Fundholders:

Practice of five doctors serving a town centre population. Third wave. Interviewee: male, white, middle-age, lead fundholder.

Seven doctor Practice serving established section of major town. Third wave. Interviewee: male, white, middle-age, not lead fundholder.

Six doctor small town Practice sharing with a neighbouring Practice the immediate and surrounding village population. Third wave. Interviewee: male, white, middle-age, lead fundholder.

Four doctor Practice covering a small town. First wave. Interviewee: male, white, middle-age, lead fundholder.

Two doctor Practice in small but rapidly expanding town. Fifth wave. Interviewee male, white, not from UK, youngest of all male interviewees, lead fundholder.

Five doctor small town and rural Practice. Third wave. Interviewee: male, white, middle-age, lead fundholder.

Four doctor Practice serving a medium size town and rural population also serving small local hospital. Third wave. Interviewee: female, white, youngest of all GPs I interviewed, lead fundholder though in close conjunction with the senior partner of the Practice

Three doctor Practice in small town quite remote from other major population sites. Second wave. Interviewee: male, white, middle-age, lead fundholder.

Three doctor Practice in growing estate on outskirts of medium size town. Third wave. Interviewee: male, white, middle-aged, lead fundholder.

Five doctor Practice based in large village and covering surrounding rural population. Firth wave. Interviewee: male, white, middle-aged, lead fundholder

Four Non-fundholders:

Four doctor Practice in the largest town of the area. Patient population described as “mainly blue collar”. Interviewee: female, white, middle-age.

Five doctor Practice, the only one in a small town covering the immediate population and more than 20 surrounding villages. Interviewee: male, white, middle-age, senior partner.

Two doctor small town Practice. Interviewee: male, white, middle-age, senior partner.

Four doctor Practice in new development area of major town. Interviewee: male, white, middle-age.
