Plochg, T.

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.

UvA-DARE (Digital Academic Repository)

Link to publication
Chapter 3

Talking towards excellence: a theoretical underpinning of the dialogue between doctors and managers

Abstract

Purpose: To explore theoretically the reasons for the modest uptake of clinical governance practices by taking the literature on the origin of tensions between doctors and managers as the starting point.

Approach: The approaches of doctors and managers to the division and coordination of medical work are analysed theoretically from a twofold perspective that combines the insights from sociologists' theories on 'professionalism' and administrative scientists' theories on 'management science'.

Findings: The combined perspective theoretically explains the problems between doctors and managers that frustrate the uptake of clinical governance practices. By inference from this theoretical analysis, a twofold agenda for a constructive dialogue is proposed. Doctors and managers must develop a shared vision on the division and coordination of medical work as well as discussing the values, norms and goals underlying patient care. It is questionable, however, whether this agenda is adequately addressed.

Originality / value: This paper provides a theoretical underpinning for the dialogue between doctors and managers. It might be enlightening for all doctors and managers working in the field.
Introduction

The ultimate goal of clinical governance is to change the culture of health care provision so that quality improvement becomes routine in medical practice and health services management. This cultural change should make medical professionals familiar with continuous quality improvement (i.e. evidence-based medicine, guidelines) on the one hand and a system of regulation to prevent unacceptable care on the other (i.e. stipulating and monitoring minimum standards of care and service availability, regular appraisal and revalidation of doctors). Although progress has been made, the desired large-scale cultural shift has not been observed or reported [1-3]. This is not surprising as cultural change amongst medical professionals is hard to achieve and empirical evidence on effective interventions is scarce [4,5].

However, on the basis of existing scientific literature it is possible to explore the reasons why so many well-intended initiatives of both doctors and managers fail and how to solve the paradox between medicine and management that seems embedded in the term 'clinical governance'. Debates on the origin and nature of tensions between doctors and managers provide a good starting point for this exploration. The current conclusion of these debates is to call for a constructive dialogue between them. Such a dialogue is expected to ease the existing tensions, but has to be discovered locally and continually maintained [6]. Following this line of reasoning yields the question what this dialogue should be about and how to orchestrate both the talking and listening.

To answer this question, in this paper we theoretically explore the approach of doctors and managers to the division and coordination of medical work from a twofold perspective that combines the insights from sociologists' theories on 'professionalism' and administrative scientists' theories on 'management science'. Using this perspective, we will infer practical solutions. Subsequently, we promote an agenda for a constructive dialogue. The concluding paragraph discusses how current clinical governance initiatives could trigger a
constructive dialogue that ultimately influences a culture of clinical excellence.

**An explanatory framework:**
the division of medical labour

It is a utopia that an individual doctor can practice the full spectrum of medicine. This notion has major consequences for the organisation of health care. It implies dividing medical labour in separate but related acts. Sociologists such as Abbott (1988) and Freidson (2001) describe in their theories on professionalism how doctors divide and coordinate medical work. They take the professional as the starting point for their theories [7,8]. Managers on the other hand, follow the various principles of management science, which includes theories on processes (i.e. Taylor 1911) and systems (i.e. Mintzberg 1983) [9,10]. We hypothesise that problems between doctors and managers originate from the differences between these principles.

**Medical professionalism: doctors’ division of labour**

Doctors have the privilege to divide and coordinate their own working processes. This privilege is founded in the nature and exclusiveness of medical work. Its nature is to apply expertise knowledge and skills on health problems through the acts of diagnosis, reflection and treatment [7]. It is exclusive, as in society nobody else is assumed to be capable of medical work, or is allowed to do it. Taking their privilege into consideration, doctors divide the full spectrum of medicine into specialities. Each speciality covers a circumscribed domain of medicine that an individual doctor can handle. At the same time the body of medical knowledge and skills underpinning each speciality are made exclusive. Only doctors trained in the speciality are authorised to practice medicine in the domain.

However, doctors’ divisions of labour are not fixed. Due to external developments and competition of other specialities, expertise can lose its exclusiveness. The body of knowledge underpinning a speciality becomes outdated and/or other specialities take over the
domain when they acquire superior expertise, technologies or skills. These threats are apparent as medical knowledge, skills and technology develop continuously and rapidly. For example, the diffusion of angiography influenced the domains of cardiology, cardio-surgery and radiology [11,12], and endoscopy the domains of internal medicine, gastroenterology and radiology.

When various specialties are working together within a hospital organisation, turf battles reflect this continuous fight over domains. Although all specialties are considered equal, their mutual dependencies result in informal hierarchies where support specialties (e.g. anaesthesiology, lab-medicine and radiology) are continuously striving to control their dependencies on surgeons and specialists in internal medicine.

To maintain and protect domains, doctors use at least five strategies. First, doctors consolidate and expand their expertise through differentiation. By becoming excellent in performing specific acts, doctors can maintain the authority over a domain. Consequently domains become narrower and deeper, explaining the increasing number of (sub)-specialties. Second, doctors delegate labour to non-physicians such as nurse practitioners and paramedics, while keeping authority over their domain. The strategy of delegation gives an explanation for the lack of differentiation between doctors and non-clinicians with respect to patients treated [13]. Third, doctors influence patient flows in order to control their dependencies on referrals of other doctors. They strive for having their ‘own’ patient population. An example is the introduction of ‘pain clinics’ by anaesthesiologists [14]. Fourth, support specialists use the (hospital) organisation to influence their own position. They actively participate in committees (e.g. drugs committee, hospital infection committee, incident committee) to affect the standardisation of care processes (e.g. guidelines on medication use, guidelines for antibiotic use, reporting procedures for incidents) [15]. Finally, doctors use quality improvement activities such as practice guidelines, medical audit and ‘visitatie’ (peer review) to claim and legitimatis their own domains [16-18].
‘Medical professionalism’ is beneficial as it brings along a culture of clinical excellence. Doctors are forced to continuously renew their individual expertise as well as the knowledge underpinning their specialty. This strive for exclusiveness drives continuous innovation and quality improvement in medicine. However, the weakness of professionalism is that it reinforces an inward orientation and encourages individualism. This fragments the care delivery process. In the past, doctors’ expertise sufficed to coordinate complete patient episodes. Nowadays patients need medical care covered by multiple specialities, implying that doctors should collaborate to coordinate medical work. As specialties compete over domains, they are reluctant to share authority with each other. Their domain might otherwise be lost. Consequently, care pathways are disconnected, which has become one of the major criticisms of medical professionalism.

**Management science: managers’ division of labour**

Fragmentation of medical care delivery, poor quality care and societal issues such as cost control has legitimised management intrusion in health care [19]. Managers divide labour in the light of the organisations’ goals and then recruit, pay, coordinate, and control other people to carry out the separated acts. Managers’ divisions of labour basically follow the principle of ‘bureaucratisation’. This is the process of designing a hierarchical structure that prescribes by codified rules and procedures who must do what [20].

However, ‘bureaucratisation’ is not necessarily effective in achieving the goals of the organisation, as ‘workers’ may have different goals and interests to managers. This tension pinpoints the heart of managerial work. Managers’ must continuously weigh multiple goals and interests to optimally design working processes. For the past century various administrative scientists have promoted different approaches to address this tension thereby expanding the principles managers can follow.

Mintzberg (1983) has introduced the concept of the ‘professional bureaucracy’ that provides a vision on how to handle this tension in knowledge intensive organisations employing professionals such as
a hospital. Managers in these organisations should primarily secure coordination of separated working processes by carefully employing experts (coordination through standardising expertise) rather than mutual adjustment, direct supervision, or standardisation of processes and outcomes [10].

Despite Mintzberg's analysis, health care management increasingly focuses on standardising processes and outcomes. Ironically, this is fuelled by the development of evidence-based medicine, practice guidelines and performance measurement. The rationales behind these approaches are to synthesise medical evidence, to assist medical decision-making and to improve patient care. However, managers have adapted these approaches to standardise hospital processes and outcomes thereby violating these rationales. Examples in this regard are 'managed care' in the US [21] and the regulatory approach towards accountability in the UK [22].

Practical solutions

Combining professionalism and management science theories provides an explanatory frame for the problems between doctors and managers that is broad enough to theoretically underpin the policy term 'clinical governance'. As long as it is impossible to 'manufacture' health and medical care is more than service delivery, professionally divided labour is needed. At the same time we cannot ignore the fragmented, ineffective and inefficient delivery of care, which calls for management involvement. Therefore, there is no other solution than trying to balance them, which underscores the call for a constructive dialogue [6]. Our argument gives new meaning to already existing practical solutions, quality improvement initiatives and innovations. From the framework the following practical solutions can be inferred:

- Doctors themselves have to solve the lack of coordination in medical work. This forces doctors to adapt a process orientation enabling them to be a responsible again for complete patient episodes. Such a process orientation must be reconciled with doctors' division
of labour. One option is ‘professionalising’ the medical expertise to coordinate complete patients episodes again. The introduction of generalists such as a hospitalist or a hospital physician is exemplifying in this regard [23,24]. These specialties are oriented towards specific patient groups rather than a technology or an organ. Another option is pooling medical expertise (i.e. multidisciplinary assessments and teamwork) necessary to coordinate complete patient episodes [25]. A last option is drawing doctors into management [26,27]. However, doctor-managers seem mostly involved in broader strategical issues. They tend to be managers who are also doctors rather than doctors who manage professional working processes in the primary processes of patient care.

— Managers should be prudent with management interventions in patient care and fill the void of medical professionalism. Their interventions will be in vain when they run counter to the doctors’ division of labour. Instead, managers should channel professionalism, which means encouraging its strengths (i.e. continuous innovation and quality improvement) and counter its weaknesses (i.e. turf battles, disconnected pathways). Concepts of the ‘professional bureaucracy’, the ‘learning organisation’, the ‘soft bureaucracy’ and ‘knowledge management’ are helpful in this respect, especially if used in a complementary fashion[10,28-30].

— Financial and legal structures should be made more supportive. Perverse incentives structures exist in several countries, impeding a constructive dialogue at the outset. Incentives should be aligned in such a way that doctors and managers have a common interest to start a constructive dialogue [31,32].

— Politicians and policymakers should enact a societal debate on priority setting in health care and make clear choices. While this debate is often absent, doctors and managers are forced to set priorities and allocate scarce resources themselves. However, priority setting in health care should not be debated at the institutional level. It undermines doctor-manager relationships, impeding a constructive dialogue beforehand. Due to varying values, doctors and managers intrinsically disagree. Doctors want to maximise the use
of resources in the interests of their patients, while managers want
the most cost-effective use of resources in the interest of all patient
groups that are relevant for the organisation.

Agenda for a constructive dialogue

The origin of the tensions between doctors and managers cannot be
easily resolved. The suggested solutions imply a lot of ‘homework’
for doctors, managers as well as policymakers and politicians. How-
ever, their individual efforts can only be effective when they are part
of a broader dialogue. The agenda of this dialogue should address
two major issues:

First, doctors and managers must develop a shared vision on di-
viding and coordinating medical work. It will enable them to un-
derstand and value each other’s positions and roles. Mutual under-
standing is a good starting point to build trust and to abandon the
conflict model. The twofold perspective used in this paper might be
helpful in this respect.

Second, doctors and managers should discuss the values, norms
and goals underlying patient care. This discussion must be ad-
dressed from the patients’ point of view. Serving patients needs and
demands should be leading, both on the individual and the group
level, rather than the values and interests of doctors and managers.

A constructive dialogue induced
by clinical governance?

The debate on the doctors-manager divide highlights that inducing
a constructive dialogue between doctors and managers is a compre-
hensive strategy - at least in theory. Such a dialogue is essentially
a ‘vehicle’ to build trust and mutual respect between doctors and
managers. The potential spin-off of improved doctor-manager rela-
tionships is endless and certainly may imply cultural shifts towards
a flourishing environment of clinical excellence.

It is questionable, however, whether current clinical governance
practices in the US, The Netherlands and in particularly the UK address the twofold agenda we suggest. First, the often chosen top-down strategy leaves little for a constructive dialogue [2,3]. Managers use professional leaders for the implementation of clinical governance practices rather than starting a dialogue with them: in particular, ‘rank-and-file’ doctors are ignored [33-35]. Although this strategy of using professional leaders acknowledges the nature of professionalism, favors self-regulation and has proven fertile to implement clinical governance practices, there are two stumbling blocks. One is that ‘rank-and-file’ doctors will not accept professional leaders from other specialties. Second, there is no real exchange of norms, values and goals taking place among managers, professional leaders and rank-and-file doctors. Both may imply that constructive dialogues are not emerging locally.

The challenge for managers is to channel professionalism rather than fighting or celebrating it. Specialty-specific leadership is necessary to provide leaders as well as ‘rank-and-file’ doctors information, capacity and a sense of ownership to respond locally. Research shows that doctors of distinct specialties perceive their organisational roles and positions differently. By differentiating clinical governance practices between specialties (e.g. nature of working processes, organisational features, embodiment in the health institution, opinion of involved doctors) instead of implementing blueprints, clinical governance policies can be closer aligned to the daily work of doctors [36,37]. This enhances the commitment of doctors and the opportunities for a successful dialogue to emerge.

Second, clinical governance currently combines quality assurance (i.e. regulation and inspection) and quality improvement in one single strategy. This will make doctors less inclined to be open about their performance. Their openness might have negative consequences for them [3]. This undermines a constructive dialogue at the outset.

Third, our argument suggest that restoring doctors’ ability to coordinate, to manage and to oversee complete patient episodes again, will improve the quality of care provision. This is the rational behind the concept of ‘integrated care’ [38,39]. Clinical governance
practices should incorporate these concepts and develop approaches that overarch complete patient episodes. However, for a successful approach doctors should feel themselves the owners of the process. Computer systems or support staff cannot replace their commitment.

Last, the current emphasis is on the ‘hardware’ of clinical governance (i.e. developing and setting standards/guidelines, systems for measuring performance). Political pressures will enforce approaches where managers start filling the gaps where doctors do not take the lead. This is understandable but will eventually lead further away from desired outcomes. It is essential to change the culture of health care provision. Starting a dialogue between doctors and managers at the local level can be a strategy to influence this change. As a result doctors will take the lead in coordinating care; managers will be prudent in intervening; policy makers will take responsibilities for resource allocation and respect professional norms and values; and financial and legal systems will be made more supportive. Talking to achieve excellence goes beyond measuring performance – it needs a dialogue.

References
