THE UNIVERSITY OF
NEW SOUTH WALES

CENTRE FOR CLINICAL GOVERNANCE RESEARCH IN HEALTH

Selected abstracts and citations

Clinicians as Managers

The Centre for Clinical Governance Research in Health undertakes strategic research, evaluations and research-based projects of national and international standing with a core interest to investigate health sector issues of policy, culture, systems, governance and leadership.

Clinicians as Managers
Selected abstracts and citations

Duration of project

October-November 2003

Search period

See below to 7th October 2003

Key words searched

Clinician (or doctor) as manager; Clinician (or doctor) and manager combined; Clinician (or doctor) management.

Databases searched

- Medline from 1966, Embase: Excerpta Medica from 1988, CINAHL from 1982, IBSS (International Bibliography of the Social Sciences) from 1990, Emerald Fulltext from commencement of the database, Science Direct from 1967, Proquest (ABI Global, Health Module, Medical Library) from commencement of the database and PsycINFO from 1892
- Hand-searching of Journal of Health, Organization and Management (1994-2003), Journal of Management in Medicine: (2002-1991), Leadership in Health Services (2003-1997), Health Manpower Management (1998-1992), British Journal of Clinical Governance (2002-1999), Clinical Governance: an International Journal (2003) and Health Services Management Research (2003-2001).

Criteria applied

Recent work on clinicians as managers

Articles that met the criteria were included in the project. A bibliography including citations and abstracts of these articles is presented on the next pages.

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Alimo-Metcalfe, B. (1998). "360 degree feedback and leadership development." International Journal of Selection and Assessment 6(1): 35-44.

Abstract If we had to identify the major areas of growth in relation to techniques for supporting leadership development, it would have to include use of 360 degree feedback. At two recent US conferences dedicated to presentations by researchers and practitioners on the subject of leadership assessment and development, the topic of multi-rater or multi-source feedback, as it is also known, formed a key component. This paper will outline in some of the reasons why this is the case, and some of the research findings that have emerged in the last few years including issues relating to gender and perceptions of leadership. It will also describe how the author has been involved in introducing 360 degree feedback processes in several public sector organizations in the UK, together with lessons that have emerged.

Alimo-Metcalfe, B. and J. Lawler (2001). "Leadership development in UK companies at the beginning of the twenty-first century. Lessons for the NHS?" Journal of Management in Medicine 15(5): 387-404.

Abstract This paper states that the development of leadership in the NHS is currently high on the agenda of the Department of Health, the government and local health sector organizations. It reports the findings of a study of public and private sector organizations, exploring the development of their in-house leadership skills. The paper also outlines the findings in depth and discusses the implications for health organizations.

Allen, D. (1995). "Doctors in management or the revenge of the conquered." Journal of Management in Medicine 9(4): 44-50.

Abstract A historical perspective on the role of doctors in management is presented as a way of describing the current situation and the problems inherent in doctors as managers without appropriate training. The changes in the attitudes of doctors following participation in management training programs are described, and the importance of encouraging doctors to continue to participate in such programs designed specifically for their needs is discussed.

Atun, R. A. (1997). "Should doctors manage or be managed?" Clinician in Management 6(3): 8-13.

Atun, R. A. (2003). "Doctors and managers need to speak a common language." British Medical Journal 326(22 March): 655.

Balderson, S. and U. MacFadyen (1994). "Management training for doctors: an in-house approach." Journal of Management in Medicine 8(6): 17-19.

Abstract Having recognized the importance and inevitability of doctors becoming involved in the management of National Health Service (NHS) Trusts, the Leicester Royal Infirmary NHS Trust initiated its own in-house management development program for senior medical staff. The program is described, and some of the benefits already realized are identified, including its role in facilitating a shift in the management agenda from managers to doctors.

Batten, M. (1995). "Moving from clinician to manager." Rehabilitation Management 8(4): 39-42.

Abstract Therapists must add business and management skills to their clinical repertoire to be successful practitioners.

Bezzina, M. B., L. B. Fischer, L. Harden, K. Perkin and D. Walker (2001). "Leadership in uncharted territory: developing the role of professional practice leader." International Journal of Health Care Quality Assurance 14(6/7): vi-xi.

Abstract St. Joseph's Health Care London is an amalgamated 3-site teaching hospital in London, Ontario, Canada. This paper shows how a new role, professional practice leader (PPL), developed as St. Joseph's shifted from department-based hierarchical management to team-based management. PPLs provide leadership within a shared decision making, outcome-focused environment. PPLs play an integral role in developing and supporting clinical decision-making structures. They provide corporate leadership in setting guidelines for professional practice and in promoting quality practice in budget and strategic planning. In an evolving organization, they maintain focus on clarifying and understanding professional and organizational accountability. PPLs support and facilitate professional development and clinical education. They provide external links with other health care organizations, educational institutions and community partners. This role is relationship-oriented and involves both doing and teaching the skills of facilitating, mentoring and coaching. Developing a new role involves establishing new values and forging collaborative mutually rewarding relationships.

Braithwaite, J. (1993). "Identifying the elements in the Australian health services management revolution." Australian Journal of Public Administration 52(4): 417-430.

Abstract Several commentators have noted the accelerating turbulence occuring in health care at the present time. Indisputably, hospitals in Australia are going through a significant period of transition. It is argued in this papaer that the magnitude of these changes will result in those organisations that we call hospitals in the future only barely resembling their counterparts in the recent past. A desription of the movement to refrom health care policy provides the backdrop to this dicussion. This discussion of public policy initiatives broadly

imforms the debate and allows the major thesis of the paper to be explicated: that there is a health service management revolution occuring and it is taking place principally at the hospital level. Evidence for this view can be discerned from an analysis of four areas - orgaanisational structure, the quality movement, changes in the managment of hospitals and patients, and alterations in the way hsopitals are financed. Thus, the very process of the transformation as it unfolds can be glimpsed. This paper discusses the evidence in an attempt to explain the crucial factors underpinninhg the revolution.

Brooker, C., K. Collins, R. Akehurst and K. Repper (1997). "Mapping the difficulties experienced by clinicians and managers in health and social care who are seeking to develop research skills." International Journal of Nursing Studies 34(4): 278-284.

Abstract In 1994 the Department of Health commissioned project work and reviews to inform the development of a National Strategy to enhance the capacity of the NHS workforce to contribute to Research and Development. This paper reports one aspect of this review: a preliminary study mapping the difficulties experienced by clinicians and managers who sought to develop their research skills. A range of professionals were included in the sample, all of whom had applied for funding to undertake research education or training through a variety of schemes offering differing levels of support. There was a remarkable degree of consistency between the professional groups in terms of their level of training, success in achieving funding and their perception of the difficulties they faced in pursuing funding for research training--which they ranked in the same order of importance. However, two major significant differences arose: nurses and therapists rated their managers as less helpful, and they felt that completing application forms for research training was a skill that they lacked. The ranking of areas of difficulty, and the additional comments made by all respondents highlight issues that need to be addressed within a coherent strategic framework to reduce the difficulties experienced by those professionals wishing to pursue funding for research training.

Bruce, A. and S. Hill (1994). "Relationships between doctors and managers: the Scottish experience." Journal of Management in Medicine 8(5): 49-57.

Abstract Based upon empirical research conducted in 1993, the implications of efforts to bring doctors into management in Scotland are illustrated. In particular, the role of key appointments is addressed, such as the medical director and clinical directors, and the perceptions of these roles. Doctors continue to demonstrate themselves to be reluctant managers, and this continues to pose problems for the aspirations contained in the Working for Patients white paper (1989). Crucial questions must be asked about whether management represents a productive use of doctors' time and whether the National Health Service can afford premium rates for largely inexperienced

managers. For the most part, doctors are still lukewarm about a career in medical management.

Burgoyne, J. and A. Lorbiecki (1993). "Clinicians into management: the experience in context." Health Services Management Research 6(4): 248-259.

Abstract This paper interprets the experience of a sample of 60 clinicians becoming involved in formal management, mainly at hospital unit level, in the historical context of changing health service organisation. This includes the introduction of managerialism and the evolution of the NHS into a structured network based around purchase/provider relationships. The conclusion is that these clinicians are becoming involved in management, and making the personal and social adjustments necessary for this, but in a way that leaves medical culture, and their allegiance to it, at the present largely intact. This is achieved largely through the organisational mechanism of clinical directorates, which promise to function as professional groups from the clinical point of view and as business units from the managerial perspective. An argument is out forward, based on a theoretical view compatible with the data from the clinicians' experience, that this mode of medical involvement in management may operate without undue conflict in the longer term if: a) clinicians accept the degree of local professional regulation that this model applies; and b) the conflict between medical need and available resource can be dealt with elsewhere in the system without passing it back to hospitals and clinical directorates. On the other hand it is possible that conflict will increase if the consequences of management control systems and objectives percolate down through the management hierarchy and cross into the medical domain, via clinical directorates.

Carpenter, C. E., E. J. Proenca and D. B. Nash (1998). "Clinical decision making - what every non-clinician manger should know what was never taught." The Journal of Health Administration Education 16(4): 357-375.

Abstract The management of health care system requires making decisions and establishing policies that can affect the process of patient care. Clinicians often complain that these decisions and policies are made by people without clinical training. Clinical knowledge is not a prerequisite for a career in health policy or management. Even graduates of accredited health administration programs are not required to understand the process of clinical decision making or the nature of medical practice. Much of the health services literature advocates a shared decision-making model for clinicians and managers. However, most of the literature focuses on how to involve physicians in management decision making; almost none discusses management involvement in clinical decisions. This paper briefly examines how non-clinician managers can support the clinical decision-making process and then specifies the knowledge and skills required for them to play this role.

Cordes, D. H., D. F. Rea, J. Rea and A. Vuturo (1994). "Training the clinician-manager: assessing the reality." Journal of Occupational Medicine 36(9): 1010-1014.

Abstract Occupational medicine residents at the University of Arizona have been introduced to administrative skills and issues as part of residency training since 1983. A questionnaire survey of 17 program graduates was conducted to assess effectiveness of training and applicability of skills to present job position. Seventeen of the graduates surveyed (100%) returned a completed questionnaire. Graduates rated the extent to which certain training activities improved administrative skills, such as community-based rotations, a 1-month administration rotation, chief resident responsibilities, committee work, program or clinic administration, and residency training overall. Although ratings overall were low, we believe this stems from the need for training that residents discover on the job. The survey emphasized the importance of administrative training during the residency years and underscored the need for renewed training efforts on our part.

Cowling, A. and K. Newman (1994). "Turning doctors into managers: an evaluation of a major NHS initiate to improve the managerial capabilities of medical consultants." Human Resource Management Journal 4(4): 1-13.

Currie, G. (1993). "Management development for clinicians: the influence of organization structure." Health Manpower Management 19(1): 4-7.

Abstract The influence of organization structure upon the success of management development interventions is identified within the West Birmingham Health Authority. The main points from this research, which took place in the UK from August 1990 to February 1992, are: 1. Training interventions of the type that involve a radical change in behavior for clinicians are successful where integrated with cultural and structural changes such as multidisciplinary team working. 2. Ward-based clinicians worked in teams that consisted of a single discipline. 3. Organizational structure influenced response to training. 4. The nature of professional work must be recognized in designing a training intervention. 5. On a broader basis, cultural change is an objective, with organization development as a potential solution. Linking back to theory, the research suggests the following conditions for radical behavior changes to result from management development. First, structures should be more reflective of machine bureaucracy or adhocracy. Second, forces for efficiency and innovation should be evident. Where structure is reflective of the professional bureaucracy and the force for proficiency is at the fore, attempted behavior changes should be of an incremental type.

Currie, G. (1994). "Evaluation of management qualifications." Journal of Management Development 13(3): 22-26.

Abstract Behavior changes in an organization should be evaluated following management development. A training intervention took place within the Family and Preventive Unit of a district health authority. The teambuilding training was carried out against a background of change in the health service. In all, 30 potential or actual team leaders participated in the program. Quantitative and qualitative methods were used to collect data. Action plans were drawn up at the end of the program (potential actions), and were followed up by self-reports (implementation actions). It was found that changes in the behavior of teams and individuals may not be attributable to the training. The questionnaire completed in pre-training may be inaccurate because individuals' assessment of behavior is contaminated by training. The suspicion with which clinicians regarded management may have contaminated responses.

Davies, H. T. O., C. L. Hodges and T. G. Rundall (2003). "Views of doctors and managers on the doctor-manager relationship in the NHS." British Medical Journal 326(22 March): 626-628.

Abstract A well functioning relationship between doctors and managers is crucial if government plans for “modernising” the NHS are to deliver real service improvements. We aimed to shed some light on current perceptions of the doctor-manager relationship by examining areas of convergence or divergence of views among a large sample of doctors and managers in the NHS.

Davies, H. T. O. and S. Harrison (2003). "Trends in the doctor-manager relationship." British Medical Journal 326(22 March): 646-649.

Abstract Doctors are discontented, and one reason is their dissatisfaction with their relationship with managers. This article explores how management structures have changed over the past few decades and explains how a better understanding of the dynamics behind healthcare delivery might help to ease the tensions between doctors and their managers.

Davis, E. (1997). "The leadership role of health services managers." International Journal of Health Care Quality Assurance 10(4): i-iv.

Delesie, L. (1998). "Bridging the gap between clinicians and health managers." European Journal of Operational Research 105(2): 248-256.

Abstract This contribution is about bridging the gap between professionals and managers in health care: clinicians on the one hand and managers on the other hand. The paper looks at the problems along the road ahead: those that confront the governmental authorities and those that confront the health care sector. It identifies the driving forces that confront the health care sector and shows in what direction they are pushing management. Three steps are indicated to bridge the gap between clinicians and managers: (1) New discussion forums; (2) patient information systems; (3) communication tools. Operational Research

can and should contribute. However, some shifts in emphasis are necessary. Three propositions are put forward: (1). Operational Research should infiltrate the discussion forums on health care; (2) Operational Research should orient itself to the "operationalisation" of the thousands of basic concepts and indicators used in health care rather than to the formulation of models which take all these concepts and indicators for granted; (3) Operational Research can contribute by helping to master the voluminous data in sensible ways in order to arrive at information on health, health care and health care management... under any type of constraint, resource or otherwise. This information needs, however, to be communicated.

Dewdney, J. C. (1999). "Will physicians replace MHAs? Reflections from Australia." Physician Executive 22(2): 11-14.

Abstract Tom Weil, in the preceding article, sees the physician executive playing an increasingly significant role in negotiations between payers and service providers, in offering the public acceptable explanations for the inevitable changes in the provision of care, and in developing more cost-effective methods of delivering high-quality health care at affordable prices. Effective involvement of physician executives will be facilitated by their having received professional training somewhat different from that of the traditional MHA. How do these prognostications relate to the health care scene in Australia? Factors that must be taken into account in considering their applicability to Australia include differences in the structure and management of the Australian health care system, the current state of that system, the background of the leadership that makes the key managerial decisions in the Australian system, and emerging trends within the system.

Doolin, B. (2001). "Doctors as managers." Public Management Review 3(2): 231-254.

Abstract In a corporated New Zealand public hospital, senior management introduced a strategy of clinical leadership intended to incorporate clinicians more fully within some system of organizational control, and to make them accountable for the resources consumed as a consequence of their treatment decision. An organizational restructuring created semi-autonomous business units based around clinical specialities and headed by clinician managers. Clinician managers played a boundary role between their professional colleagues and management. In the short term, a number of senior clinicians adapted to this role and there was some evidence for their acculturation into managerial identifications. However, the majority of clinician managers acted to absorb change rather than actively champion change. For many clinical units, clinical practice continued more or less unchanged. The concept of loosely coupled systems is used to explain this separation of internal operations from organizational form.

Dopson, S. (1994). "Management: the one disease consultants did not think existed." Journal of Management in Medicine 8(5): 25-36.

Abstract Considers progress made in involving doctors in management, drawing on available ethnographies of local health-care systems and a small-scale study of consultants who have moved into clinical director roles or the equivalent. Specifically considers the extent to which the sample believes consultant roles have changed as a result of the recent reorganization of the NHS and general concerns about the involvement of doctors in management.

Duckett, S. (1994). "Hospital and departmental management in the era or accountability addressing the new management challenges." Australian Health Review 17(3): 116-131.

Duran-Arenas, L. and M. Kennedy (1991). "The constitution of physician's power: a theoretical framework for comparative analysis." Social Science & Medicine 32(4): 643-648.

Abstract Drawing on literatures documenting the experience of physicians in both European and American societies, a new theoretical framework for explaining variations in the professional power of physicians is provided. Most studies of professions have used professional organization as the principal explanatory variable, with state policy and the organization of civil society as secondary mediating factors. Our approach instead treats strategies of state power and forms of civil society as central features shaping the ability of the profession to exert power. Such a three-dimensional approach not only allows us to make more powerful classifications explaining contemporary differences, but also allows us to trace historical shifts and anticipate alternative futures in professional power. For example, in those societies where the state's intervention is limited and civil society is pluralistic, professional power is potentially greatest. But increasing state power does not necessarily reduce professional power. Where the state is most powerful and organizes all groups in civil society, professionals and society can be united in common struggle against the state. In response to that, it is likely that such centralized states will opt for corporatist solutions to maximize the internal differentiation of society and pit those once allied against one another, and prelude the organization of powerful autonomous interest groups.

Duran-Arenas, L., A. M.B. and J. F. Mora (1992). "The role of doctors as health care managers: an international perspective." Social Science & Medicine 35(4): 549-555.

Abstract The participation of physicians in health care management has followed different paths in developed and developing countries. However, we can say that in most of the countries the physicians have had cyclical patterns of participation and withdrawal from health care management. It is readily apparent

that these patterns are different in each country. We propose to take into account three different levels of analysis in which different factors interact to define the country specific pattern of physician involvement in health care management, as well as to assess the international convergence and divergence paths on physician participation. We present here a conceptual framework that could facilitate the analysis of this theme under a comparative perspective. We start by discussing a conceptual framework of the determinants of physician participation in health care management. Then, we assess the current trends and perspectives in both developed and Latin American countries of physician participation in health care management.

Eastmann, C. J. and L. Fulop (1997). "Management for clinicians or the case of 'bringing the mountain to Mohammed'." International Journal of Production Economics 52(1-2): 15-30.

Abstract This paper reports on a new and innovative initiatives undertaken to develop the first intensive residential management program for clinician managers in Australian hospitals. A number of health care experts have argued that the reform of the health system, and public hospitals in particular, can only occur if clinicians are given, and take on, greater management responsibilities. This paper outlines why there has been resistance to this occurring and the pressures for this to change. It then discusses how the introduction of the Management for Clinicians Program has begun to enhance and encourage a greater acceptance of the clinician manager role in hospitals. It describes how the program seeks to promote a greater understanding and acceptance of management amongst clinicians. The paper also outlines how the program was designed and implemented. While short courses for clinician managers have been available for sometime in Australia, the program described in this paper is path breaking for a number of reasons.

Edmonstone, J. (2000). "Empowerment in the NHS: does shared governance offer a way forward?" Journal of Nursing Management 8(5): 1-7.

Abstract This paper explores definitions of the notion 'empowerment', noting that it is both an ambiguous and a contested concept, with antecedents in left-of-centre political ideologies, but appropriated into the language of managerial transformation. Empowerment's origins are considered in the light of efforts to improve the UK's economic performance in relation to its competitors, drawing particularly on Japanese management practice.
It distinguishes between employee participation and employee involvement, noting that shared governance in nursing is a form of indirect employee involvement that is profoundly antihierarchical. It examines those factors likely to enable (and disable) the development of empowerment through shared governance. The paper concludes that an instrumental/regulatory approach is likely to fail in highly professionalized organizations such as the NHS, while an

expressive/revelatory approach, expressive of professional values, is more likely to succeed.

Edmonstone, J. and J. Western (2002). "Leadership development in health care: what do we know?" Journal of Management in Medicine 16(1): 34-47.

Abstract The NHS in England has developed a strong focus on clinical and managerial leadership. The article describes both emerging ideas on leadership models and approaches to developing leaders as a background to the description of two evaluation studies of leadership programmes for executive directors and the lessons learned for the future.

Edwards, N. and M. Marshall (2003). "Doctors and managers." British Medical Journal 326: 116-117.

Eubanks, P. (1991). "Clinicians: manage your move to manager." Hospitals & Health Networks 65(5): 60.

Abstract To ensure that the transition from clinician to manager is smooth, human resource experts suggest the following steps: 1. Test for a real desire to do the work of a manager by considering whether the rewards of managing are adequate and potentially satisfying. 2. Seek management training through hospitals, professional associations, and educational institutions. 3. Seek out managerial opportunities while still a clinician, sending a message to superiors that the clinician is serious about moving up and providing evidence that the clinician is capable of doing the job. 4. Develop "people skills." 5. Find a mentor or coach who can answer questions and serve as a role model. 6. Beware of traps that undercut the ability to manage; for instance, a new manager might continue performing clinical tasks instead of delegating them.

Farebrother, M., J. Asbridge, C. Miles and L. Patterson (1991). "Involving health professionals in management: a transatlantic comparison." Journal of Management in Medicine 5(4): 20-26.

Abstract Initiatives for greater involvement of health care professionals, particularly consultants, in health care management in North America and the United Kingdom are compared. Although the historical backgrounds are different, there are similarities both with the problems and the solutions, and these are discussed.

Fitzgerald, L. and J. Stuart (1992). "Clinicians into management: on the change agenda or not?" Health Services Management Research 5(2): 137-146.

Abstract This article examines the issue of drawing medical consultants into managerial decision making. It commences by examining both historically and

comparatively the influences on doctors and their reluctance to adopt managerial roles and responsibilities. It progresses to an analysis of the impact of the NHS and Community Care Act particularly in relation to the separation of purchaser and providers and the development of contracting mechanisms. The argument presented suggests that the rapid adoption of the clinical directorate model, as the favored mode of organisation in acute units, has led to clinicians assuming imitation general manager roles. The authors question whether this is the best use of the unique skills and time of clinicians. They compare with experience in the USA and propose that collaborative working between doctors and general managers is essential in health care. The article suggests a set of tasks for clinician managers and then discuss the issues of training support and development which will be required if clinicians are to perform these tasks effectively.

Fitzgerald, L. (1994). "Moving clinicians into management. A professional challenge or threat?" Journal of Management in Medicine 8(6): 32-44.

Abstract An examination is made of the issue of involving clinicians in management and the management processes. A consideration is made of the effect of the changing context of practice and the pressures that are imposed on the medical profession by this involvement. The study primarily draws on the results of a recently completed research project which tracks a cohort of clinicians in the UK as they assume management responsibilities and follows their progress as they undertake training at business schools. A number of key issues are addressed, including: 1. What has motivated the clinician to accept or apply for a management role? 2. How has the role of clinical manager been conceptualized, and what is the impact of the concepts in use? 3. How do the professional incumbents of management roles perceive their position and their professional identification, and how do they relate to other professionals?

Fitzgerald, L. (1997). "Clinical management as boundary management: a comparative analysis of Canadian and UK healthcare institutions." International Journal of Public Sector Management 10(2): 5-20.

Abstract This article focuses on the critical role played by professionals in the management of health-care institutions in the UK and Canada. Using empirical data, it examines the structural models of clinical management, the roles of clinical managers and their relationships with colleague professionals. It compares the approaches taken in the UK and Canada, and explores issues of context, history and relative power. It questions the extent to which professionals are losing autonomy to other professions and management. In particular it examines whether the sharing of power inter-professionally may lead to greater, overall collective professional autonomy. It develops themes of the contextual influences on the process of change, and whether professionals are more effectively managed by internal or external processes of control. At the collective level, it is clear that in the UK the profession has only relatively recently exerted

pressure towards standardized audit procedures and has not progressed as far as Canada down the accreditation path.

Forbes, T. and N. Prime (1999). "Changing domains in the management process." Journal of Management in Medicine 13(2): 105-113.

Abstract Forbes and Prime examine a group of radiographers developing management roles within the backdrop of a chancing National Health Service (NHS). A comparative study of 25 Scottish and English radiographer managers are interviewed using semi-structured interviews. Interviews were based on a number of issues associated with moving from a clinical professional to a clinical manager and are analyzed using domain theory. The interviews formed a number of emerging themes. Radiographer managers are forming new hybrid manager roles which have been developing within a changing NHS. This transition was not easy for this group of radiographer managers. However, they show resilience in undertaking both operational and strategic management decisions, while using their clinical background to inform their decision making.

Gatrell, J. and T. White (1996). "Doctors and management - the development dilemma." Journal of Management in Medicine 10(2): 6-12.

Abstract Identifies managerial knowledge and skills from undergraduate to medical director level and considers the development of a core management training strategy and development programme, transferable on a national basis. Reports on a questionnaire survey plus in-depth interviews with doctors and senior managers divided between grades covering hospitals, general practices and public health services. Explains that the model evolved is a synthesis of managerial models set in the context of doctors' work. Concludes that doctors agreed that more support and training from their organizations would have been useful, and that managers were generally supportive of doctors becoming involved in management, although some harboured doubts about their willingness or the effects such moves would have on established management career structures. Contends that there appears to be a 30:70 split between doctors receptive to the concept of management and those against.

Gatrell, J. and T. White (1997). "Doctors and management - a model for change." Health Manpower Management 23(1): 31-35.

Abstract Views the closure of a hospital in an unusual manner. Questions the role of health workers as "care in the community" comes to the fore. Raises questions about psychiatric hospitals, people with mental health problems and mental health workers.

Godwin, A. (1996). "The clinician-manager model in the National Health Service: conflicting social defence systems?" Psychoanalytic Psychotherapy 10(2): 125-133.

Abstract Clinicians are increasingly being required to take on additional management duties in today's National Health Service (NHS). The framework of social defenses provides 1 way of understanding the role conflict of these clinician-mangers. It is proposed that clinicians cope with the anxieties of health care work by projecting unacceptable aspects of themselves into managers and that managers develop defensive social structures involving projection into clinicians. The current NHS culture and the associated increased anxiety exacerbates the reliance on these defensive structures. This makes collaboration between clinicians and managers particularly difficult, and results in increased anxiety for those who occupy the dual role

Gupta, R. C. and P. Labbett (1994). "Creative problem-solving techniques: relevance to doctors in management?" Journal of Management in Medicine 8(1): 24-28.

Abstract In the UK, recent National Health Service reforms have had a profound impact on the role of clinicians in the field of management. Traditionally this has been a role eschewed by clinicians, but the evolution of the clinical directorate model has now encouraged senior members of the medical profession to address more positively managerial and management issues. If clinicians are to embrace enthusiastically the management role, it is clear that their awareness of the range of techniques available to them is raised to its maximum potential. In this respect, the relevance of some more radical creative problem-solving techniques within a practical environment is explored. The concentration is on 2 specific techniques which were put to trial in real working situations. However, in addition to the techniques addressed, there are a range of alternative problem-solving techniques which may be more appropriate. Having piloted the 2 creative problem-solving techniques described, the practical conclusions were that their application had developed better team working and spirit, enhanced the quality of patient care delivered by the team, and improved productivity and outcomes.

Hadley, R. and D. Forster, Eds. (1993). Doctors as managers: experiences in the frontline of the NHS. Essex, Longman.

Hadley, R. and D. Forster (1995). "Where the reform did not reach: doctors as front line managers." Journal of Management in Medicine 9(5): 27-38.

Abstract The importance of the behavioral dimension of the management of front line teams in the health service has been neglected both in the training of doctors and in the recent reforms of the health service. Drawing on 3 case studies carried out by doctors, the influence of the level of understanding of behavioral factors in determining the effectiveness or ineffectiveness of management at this level is explored. Some implications of the discussion for giving a more central place to these factors in the selection, training and promotion of doctors are considered.

Hanafin, S. (1997). "The role of the Irish public health nurse: manager, clinician and health promoter." Health Visitor 70(8): 295-297.

Harrison, S. and J. N. W. Lim (2003). "The frontier of control: doctors and managers in the NHS 1966-1997." Clinical Governance: An International Journal 8(1): 13-18.

Abstract Summarises the impact of challenges of reorganization faced by the UK medical profession over a 30-year period up to the arrival in government of New Labour in 1997 in order to provide a historical context for the appearance of clinical governance. Investigates the NHS manager as a "diplomat", the era of "general management" and the National Health Service quasi-market. States that: managerial supremacy has increased over a long period; managerial control over medicine seemed uncertain in 1997; and a good deal of secular change has arisen from government imposing macro-level reorganization. Concludes that it remains to be seen whether these elements are capable of allowing the development of local clinical governance arrangements that carry the support of the medical profession.

Hearing, S., T. Dent, J. Swann, I. Gunaratna, I. McLellan and U. Ikidde (1999). "Maximizing the contribution make to NHS management." Health Services Management Research 12(4): 227-231.

Henry, R. C. and S. C. Hubbard (1998). "Strategies from successful transition from clinician to home care manager." Home Care Manager 2(3): 4-9.

Hernandez, S. R., C. C. Haddock, W. M. Behrendt and W. F. Klein (1991). "Management development and succession planning: lessons for health service organisations." Journal of Management Development 10(4): 19-30.

Abstract Succession planning is a conscious, relatively formal process that focuses on future management position vacancies and on the individuals internal to the organization who may be candidates to occupy these positions. Barnes Hospital (St. Louis, Missouri) initiated its management development and succession planning activities in 1988. The process consists of 2 separate components: 1. the performance appraisal process designed to align evaluation with job functions and objectives, and 2. the developmental review process, which relies heavily on an individual development plan (IDP). The IDP identifies strengths and developmental needs unique to each manager and specifies a plan of action to assist the manager in responding to these areas. Hospital wide in-service training for managers participating in the program was initiated prior to its implementation. By the end of 1989, acceptance of the program was generally high.

Hindle, J. (1991). "Managing doctors." Journal of Management in Medicine 5(4): 60-66.

Abstract What does a doctor need to acquire before entering the field of management. This article begins to explore the capabilities and qualities associated with successful managers and suggests that doctors interested in management need to review the way they are currently perceived and develop characteristics which will help them to move smoothly into the new roles which are being established for them.

Hooke, R. L. (1999). "The junior doctor manager." Hospital Medicine 60(5): 373-375.

Abstract Several organizations are employing junior doctor managers to help them implement and maintain controls on the hours worked by their colleagues, and to improve conditions. A person who has worked as a junior doctor is in a good position to understand these issues.

Horsley, S., E. Roberts, D. Barwick and D. Allen (1996). "Recent trends, future needs: management training for consultants." Journal of Management in Medicine 10(2): 47-53.

Abstract Describes the results of a postal questionnaire survey of all 1,383 hospital consultants in the North Western Region of the UK in 1994; updating a similar survey conducted in 1987. In both surveys, consultants were asked to describe their current management role, management training received and any perceived future training needs. A series of open questions in the 1994 survey explored barriers and incentives to the take-up of management training. The results show that in 1994 more doctors were taking on greater management responsibility and from an earlier age. Consequently, the proportion of consultants expressing a need for management training had risen from 62 per cent in 1987 to 73 per cent in 1994. The most useful courses were local budgeting and business planning. However, many consultants described problems in accessing training. Concludes by highlighting policy implications arising from the surveys which will need to be addressed if consultants are to fulfil their management potential.

Hunter, D. J. (1991). "Managing medicine: a response to the 'crisis'." Social Science & Medicine 32(4): 441-449.

Abstract A feature of many developed healthcare systems is the attempt to replace provider-driven services by managerially-driven services which are ostensibly more responsive to consumer preferences. Policy-maker anxious over the `crisis' of escalating costs in healthcare delivery and over the efficiency of some medical treatments and interventions are turning to managerial solutions as a means of holding professionals—primarily the medical profession—to

account for their actions. The paper uses developments in the British NHS as a case study to review and explore the issue of managing medicine. Recent and proposed reforms are designed to strengthen the managerial grip on the service. The paper casts some doubt over the likely outcome of these developments. It argues that the success of attempts to shift the frontier between management and clinical work in favour of management is by no means guaranteed. It also points to a major tension which remains to be resolved, namely, the optimum balance to be struck between a doctor's responsibility to each individual patient on the one hand and his/her responsibility to a whole population on the other.

Hunter, D. J. (1992). "Doctors as managers: poachers turned gamekeepers?" Social Science & Medicine 35(4): 557-566.

Abstract Doctors in health care systems of different types are coming under increasing pressure to take on active roles in management. Mounting concern among governments over the escalating costs of health care, coupled with a desire to improve the quality of care and render services more responsive to user preferences has resulted in management being viewed as offering an effective means of tackling these issues. Until recently, the favoured strategy was to strengthen management in order to curb doctors' discretionary decision-making. There is now a shift towards creating managers out of doctors with all that this implies for the future shape of health services. There are also issues about the training and development required for a management role, the stratification of roles within the medical profession, and the future status of lay, or non-medical managers.

The paper reviews the debate about doctors and managers and their distinctive value bases. It suggests that doctors can be involved in management as managers at two levels—meso and micro—and considers the issues raised at each level. The paper presents an analysis of the wider context in which the debate about doctors as managers is taking place. The main thesis put forward is that far from managers incorporating doctors, the end result may prove to be the other way round with `provider capture' of the management agenda in health services a distinct possibility.

In contrast to managers, doctors retain enormous public respect and support. As long as it is so doctors will remain powerful stakeholders in defining and controlling the shape and range of health services available. Their active involvement in management could lead to a strengthening of their position. It is argued that, paradoxically, this could make it more difficult for governments to challenge doctors' work practices. Medicine's traditional preoccupations and its resilience to change are likely to remain as strong as ever thereby disappointing advocates of a health and social care system located in a broader policy framework which emphasises health gain and a holistic approach to health.

Johnson, J. A. and R. W. Boss (1991). "Management development and change in a demanding health care environment." Journal of Management Development 10(4): 5-10.

Abstract The problems facing many US health care organizations may prove critical to survival for many of them. Problems arise because of: 1. increased patient demands, 2. tensions among personnel, 3. technological innovation, 4. cost-conscious purchasers of care, 5. the need to improve cost-efficiency, and 6. barriers to change within organizations. The barriers to change present problems that often seem intractable and are peculiar to this type of organization, including: 1. the health professionals' expectations of independence and autonomy, 2. the collective benefits of stability, 3. calculated opposition to change, 4. programmed behavior, 5. tunnel vision, 6. resource limitations, 7. sunk costs, 8. accumulations of official constraints on behavior, 9. unofficial and unplanned constraints on behavior, and 10. interorganizational agreements. Health service managers must be engaged in a continuous process of development at the personal and organizational levels.

Lawson, J. S. (1994). "Difficulties in the transition from clinician to manager." Physician Executive 20(7): 19-21.

Abstract Medical clinicians have for many years been managers. However, this management role has most often been in groups of other clinicians and other health personnel. Only recently have increasing numbers of medical clinicians been asked to accept responsibilities for managing hospital and health services divisions that carry financial and administrative responsibility in addition to traditional clinical responsibility. In these circumstances, it is appropriate to seek to gather information about the various issues that surround the transition from clinician to manager in a systematic way and to begin to explore the issue and any actions that might be taken to ameliorate transitional problems. Such a study was undertaken by the School of Health Services Management at the University of New South Wales, Sydney, Australia, and is reported in this article.

Llewellyn, S. (2001). ""Two-way windows": Clinicians as medical managers." Organization Studies 22(4): 593-623.

Abstract This paper uses the metaphor of the `two-way window' to understand the aspirations and activities of clinical directors (doctors with management responsibilities). Clinical directors work simultaneously with sets of ideas from both clinical practice and from management, therefore, their role (as `two-way windows') allows the possibility to create a new area of expertise - medical-management. To explore how `two-way windows' are being constituted, clinician managers in three medical organizations were interviewed. Three narratives were constructed from their accounts. The first narrative outlines the theories-in-use of clinical directors, the second and third consist of the strategizing of clinical directors as they seek to maintain their primary focus on

clinical work whilst, at the same time, developing their management expertise and influence. The paper concludes that clinical directors can relatively easily occupy the `two-way' space opened up by the mediation of medicine and management. Only a lack of financial management expertise renders their new organizational positioning vulnerable. All public bureaucracies now involve complex mediation between professionals and managers; hence, `two-way windows' will become increasingly significant in organizational development. These `two-way' roles privilege professional over managerial expertise as it is assumed that the appropriate professional training is of paramount importance. Unique professional/managerial discourses are being created in public-sector organizations. This paper provides a basis for understanding the development of such discourses.

Loan-Clarke, J. (1996). "Health-care professionals and management development." Journal of Management in Medicine 10(6): 24-35.

Abstract The article discusses the impact of a self-governing hospital trust's accredited management development programme designed for health-care professionals responsible for managing natural clinical groups. The program was a dual qualification: a level 5 national vocational qualification in management, and a diploma in management. It identifies key issues resulting from this type of programme. The article discusses participants' evaluation of the two different formats for management development. Highlights the reservations of health-care professionals in respect of competence-based management development, particularly regarding assessment of their work performance. It is recognized that when a group of senior health-care professionals are involved in a long-term in-house management development programme, they may be perceived as a threat by senior management. The article concludes that health-care professionals will only engage proactively with management development activities which they perceive to have value for them.

Lorbiecki, A. (1995). Clinicians as managers: convergence or collision? Interprofessional relations in health care. L. Mackay, K. Soothill and C. Webb. London, E. Arnold: 88-106.

Abstract During the past few years clinicians have been encouraged to become more actively involved in the management of their hospital units as a means of implementing the recent NHS reforms stemming from the Griffiths Report (1983) and the White Paper working for Patients (Department of Health, 1989). This represents a possible convergence between the different ways in which the medical body and managers organize themselves. However, in view of the significant differences in the perspectives of the medical profession and managers there is always the danger that closer relationships will lead to some sort of collision of interests. This chapter examines this dilemma in the following way. First I review the external changes and legislation which have placed greater emphasis on clinicians playing an active part in management. Then I look

at the clinicians' response to this by analysing 1) collective/organisational reactions, and b) individual experiences of their changing role. Finally I use this information to draw conclusions about the central question of convergence or collision.

Mahmood, R. and C. Chisnell (1993). "Do doctors want to become involved in management?" The Clinician in Management 2(4): 12-13.

Malcolm, L., L. Wright, P. Barnett and C. Hendry (2003). "Building a successful partnership between management and clinical leadership: experience from New Zealand." British Medical Journal 326(22 March): 653-654.

Abstract Recent New Zealand studies have shown important progress in addressing a key issue facing all health systems: the gap between clinical culture and governance or managerial culture. The key terms in this progress are partnership, quality, clinical leadership, and professionalism. Three factors have been important. Firstly, New Zealand—with a national per capita income some 20% below the mean for member countries of the Organisation for Economic Co-operation and Development—has had to make difficult choices about health priorities. This has compelled greater collaboration between clinicians and management. In primary care, major budget management—of drugs, for example—is being seen as a new form of clinical autonomy. Secondly, the Cartwright inquiry of 1988, perhaps New Zealand's equivalent of Britain's Bristol inquiry, played a key part in sensitising the medical profession to the need for greater collective professional accountability. The inquiry has also been a critical factor in the promotion of a culture of quality. Thirdly, the commercially driven reforms of the 1990s, perhaps more radical and damaging than the reforms in Britain, led to a major shake up of the clinical culture. In some secondary care settings a widening gap between clinical and management cultures led to open conflict. However, in other settings managers who were more health oriented collaborated with clinicians to build the working partnerships that are now being generally adopted. The formation by a new centre left government in 2000 of fully integrated district health boards has further promoted this partnership, perhaps best described as a “convergence of cultures.” This convergence has required from the governance or management culture a shift from a preoccupation with resource management to health outcomes as the “bottom line” of the organisation. This commitment is reinforced by the contract between government and district health boards, as set out in the New Zealand health strategy. Convergence also means the acceptance by clinicians of a key role in managing resources and in achieving the organisation's goals. Both cultures need to move—and are moving—towards a more trusting relationship that is based on a shared vision and on shared goals of better outcomes for patients and communities, within limited available resources. This partnership is a critical factor in quality improvements reported in New Zealand studies. Clinical leadership is playing a key role in this partnership. But clinical leaders, although

appointed by management, remain clinicians. They have not crossed to the "other side." They are being helped by the relatively new Clinical Leaders Association of New Zealand. Through clinical leadership, the New Zealand health system may be implementing what the sociologist Eliot Freidson calls the "third logic," an alternative to market or bureaucratic models. 8 In contrast to the failings of these models, a new professionalism may be emerging—but with clinicians becoming collectively and professionally accountable for both the quality and cost of their decisions, in a new and successful form of clinical autonomy.

Mark, A. (1991). "Clinical directorates." Health Manpower Management 17(4): 14-17.

Mark, A. (1991). "Where are the medical managers?" Journal of Management in Medicine 5(4): 6-12.

Abstract This article discusses the attempts by the National Health Service (NHS) to develop medical managers, following the introduction of general management in 1983. It suggests that problems have arisen because, so far, it has been organisational considerations and not those of individual career paths which have informed these developments. It is suggested that this new approach could lead to the development of the NHS as a learning organisation within the context of the original policy objectives.

Mark, A. (1993). "Researching the doctor manager - choosing valid methodologies." Journal of Management in Medicine 7(4): 52-59.

Abstract In a recent research study of the effects of management training for doctors working in the UK National Health Service, it has become apparent that identifying the transition from doctor to manager does not involve just a change in skills, knowledge and attitudes to the differing roles of doctors and managers. Added validity is given to this change by an acceptance, on the part of the participating doctors, of the different research techniques required of management research, compared with the standard techniques used in the practice of medicine. Positivist versus phenomenological perspectives are compared in relation to the research process itself focusing on the triangulation of methods employed and their differing outcomes. The effectiveness of the various methods are then compared in relation to the research outcomes and the changes observed.

Mark, A. (1994). "Medical Management. Reflecting on some ripples in the pond." Health Manpower Management 20(1): 18-20.

Abstract Using current research into the management training of doctors in the UK, looks at some of the personal rather than just the organizational issues which arise from the development of doctors as managers. The variety of

interpretations of the role raises a number of questions, some of which are highlighted: for example, the status of the management activity for doctors; the option of professional retreat from, or isolation in, difficult managerial roles; parttime management; disempowerment of other professionals; re-entry needs to full-time professional clinical work; women doctors as managers and the double- or even triple-glazed ceilings which they face. Some positive trends are evident, e.g. the impact of successful female chief executives as role models, the impact of training, but no one solution has emerged and this trend itself is seen as encouraging, given the context of a complex and ever changing environment.

Mark, A. (1994). "Do special health authority doctors make special managers?" Journal of Management in Medicine 8(6): 58-63.

Abstract A review is made of management training for doctors undertaken in the special health authorities in London. These are postgraduate research institutes in clinical medicine. Methodology and outcome issues are compared with the national research program completed a year earlier, and the context of comparative change between the research programs is compared. The findings, although similar to the national evaluation the previous year, identify some additions, in particular the lack of formal accountability for the management role in the NHS being undertaken by these university employees, and the differing nature of the working arrangements for these academic doctors, who are usually working as knowledge-based networkers across a number of organizations.

Mark, A. (1995). "Developing the doctor manager: reflecting on the personal costs." Health Services Management Research 8(4): 252-258.

Abstract These reflections focus on the development of doctors as managers in the National Health Service and the way that their participation is directly influenced by the personal costs perceived to their professional roles as doctors. Research has indicated some of the problems surrounding the development of doctors as managers. Although training has led to a reduction in stress, women doctors are having to contend with a glass ceiling which is double and even sometimes triple glazed, team development is not being addressed adequately, and succession planning is occurring by default rather than design. The application of domain theory to the issue can provide some guidance for the organisation, but as individual organisations like hospitals interpret these changes in a unique way, it is suggested that the key training for the future will need to focus on transition skills between organisations, and will require interpretive and adaptive responses from both doctors and managers if they are to continue to collaborate successfully in the managerial domain.

Martin, V. (1999). "Working together to develop health services managers." Journal of Management in Medicine 13(1): 41-50.

Abstract The developing emphasis in health and social care on working across traditional boundaries will demand different approaches to staff development. If we are to retain the strengths of expertise in the enormous number of areas represented in health and social care we will need to develop better ways of understanding each other in order to work together more effectively. This paper focuses on some of the issues raised in management development programs which have multiple objectives demanding educational and developmental support. The emphasis is on identification of issues which arise in collaboration amongst those delivering a program when they come from the different backgrounds of training and development, personal development and higher education. Some of the issues raised in partnership working between commissioning and providing organizations are also considered.

McAreavey, M. J., B. Alimo-Metcalfe and J. Connelly (2001). "How do directors of public health perceive leadership?" Journal of Management in Medicine 15(6): 446-462.

Abstract This study examines how directors of public health (DsPH) perceive effective leadership. Kelly's (1955) repertory grid technique is used. A total of 13 out of a possible 14 DsPH in one NHS region of England were interviewed. Qualitative and quantitative analysis were carried out. The findings show that male DsPH rate their leadership ability more highly than do female DsPH. Qualitative analysis produced a number of categories of constructs, some of which are perceived to be indicative of effective leadership, these being working for others, personal attributes, vision and innovation, and courage and integrity. Some categories appear to be applicable only to the UK (or to public health) and not to the existing dominant US models of leadership. In general, DsPH perceptions of effective leadership converge with current theories; most specifically the UK-based theories. This study therefore refutes any simple extrapolation of US theories of leadership to UK health organizations.

McConnell, C. (1991). "Collaborative management development: sharing a wealth of ideas and experience." Journal of Management Development 10(4): 11-18.

Abstract Two of the classic challenges encountered in supervisory or management development activity are: 1. determining the topics about which potential program attendees need to be hearing, and 2. maximizing attendee involvement in all sessions and ensuring that every participant's input is received and taken into account. A collaborative approach to the development of lower level management skills was devised and put into practice at a teaching hospital. Beginning as an open forum in which attendees questioned the instructor, it progressively evolved into a controlled "free-for-all" in which each attendee with something to contribute was able to teach the others. Dealing with one real-life problem at a time, the collaborative management development group entered into a process that eventually provided practical, usable advice for the participant

who posed the problem and tested solutions that all attendees could carry away on paper. Collaborative management development has shown itself to be an effective way of sharing knowledge and information.

Merkens, B. J. and J. S. Spencer (1998). "A successful and necessary evolution to shared leadership: a hospital's story." International Journal of Health Care Quality Assurance 11(1): i-iv.

Abstract The success and adaptability of healthcare organizations will depend more and more on their ability to draw on the capabilities of their people. Tillsonburg District Memorial Hospital, a rural Ontario hospital, has evolved an organization and culture based on shared leadership and decision-making responsibility. Today this extends to front-line teams. This did not come about, however, without continuous effort. Successful transition takes preparation, guidance, much thought, commitment and patience

Meslin, E. M., L. Lemieux-Charles and J. T. Wortley (1997). "An ethics framework for assisting clinician-managers in resource allocation decision making." Journal of Healthcare Management 42(1): 33-48.

Abstract In response to continued pressure on the Canadian healthcare system, hospitals are implementing structural changes to address issues of cost containment, utilization, and resource allocation. One strategy has been to decentralize managerial decision making to clinicians, creating "clinician-managers" (CMs). Some 3,000 hospital-based CMs were surveyed in Ontario, Canada, (including physicians, nurses, and other health professionals), in order to understand the nature and frequency of the ethical issues they face as a consequence of their involvement in resource allocation decisions, and to identify mechanisms for dealing with these problems in their hospitals. Based on the survey results, a Management Ethics Framework was developed to assist CMs to reach an ethically justifiable resolution of these types of problems, both individually, and in the context of their membership in the healthcare team. The results, and particularly the discussion that follows, represent a confluence of philosophical, clinical, and organizational perspectives on ethics and resource allocation by clinicians.

Metzger, N. (1991). "The changing health care workplace: a challenge for management development." Journal of Management Development 10(4): 53-64.

Abstract The health care industry is undergoing an incredible and rapid change. Management must move from seeking power to empowering others. A new management style - a collaborative approach - must be developed that focuses on the needs, expectations, and participation of health care employees at all levels. There is increasing evidence that, when employees are allowed to make decisions about their work, they are more productive, and when employees

are permitted to be collaborators rather than tools of management, they will be less alienated. Administrators are dealing with a complex new breed of health care employees who are far more assertive, far more knowledgeable about their rights, and far more certain about what they will and will not do. Self-reliant, trusting, and decisive supervisors produce efficient subordinates. When managers develop self-regard, they will become excellent leaders. When they deal in terms of human possibilities, they are on the road to excellence.

Nash, D. B. (2003). "Doctors and managers: mind the gap." British Medical Journal 326(22 March): 652-653.

Abstract The problem with doctor-manager relationships is well studied. The potential for these relationships to harm the working enviromnent and affect organisational performance is acknowledged and understood. The same is not true of possible solutions. To bridge this gap we invited short contributions, and we are publishing a selection of these to start the debate. This is the kind of issue where those from different sides might wish to contest all the potential solutions. We hope so. Please post your responses on bmj.com.

Newman, K., T. Pyne and A. Cowling (1996). "Junior doctors and management: myth and reality." Health Manpower Management 22(1): 32-38.

Abstract Uses an empirical investigation based on a survey of junior doctors in five NHS trust hospitals, to examine their attitudes towards both the general principle of clinical involvement in hospital management and the particular prospect of exercising such a role themselves. Finds that junior doctors, with few exceptions and irrespective of grade, were very positive towards clinical management roles in NHS trusts and were almost universally keen to assume management responsibilities when they were more senior. At the same time, finds junior doctors to have little concept of the doctor- manager role or the recognized and demanded specific preparation for assuming management responsibilities.

Packwood, T., J. Keen and M. Buxton (1991). "Process and structure: resource management and the development of sub-unit organisational structure." Health Services Management Research 5(1): 66-76.

Abstract Resource Management (RM) requires hospital units to manage their work in new ways, and the new management processes affect, and are affected by, organisation structure. This paper is concerned with these effects, reporting on the basis of a three-year evaluation of the national RM experiment that was commissioned by the DH. After briefly indicating some of the major characteristics of the RM process, the two main types of unit structures exiting in the pilot sites at the beginning of the experiment, unit disciplinary structure and clinical directorates had become more popular, another variant, clinical grouping,

had replaced the unit disciplinary structure. Both types of structure represent a movement towards sub-unit organisation, bringing the work and interests of the service providers and unit managers closer together. Their properties are likewise analysed and their implications, particularly in terms of training and organisational development, are then considered. The paper concludes by considering the causes for these structural changes, which, in the immediate time-scale, appear to owe as much to the NHS Review as to RM.

Perkins, D. (1992). "The strategic management of health services." Journal of Management Development 11(6): 31-39.

Abstract The UK's South East Thames Regional Health Authority (SETRHA) has faced considerable pressure to perform at ever higher levels of effectiveness due to an increase in demand for services, a scarcity of revenue and capital, organizational reforms, the introduction of general management, and the introduction of the managed market. The simultaneous development of a competency statement, individual assessment and development of programs, and a range of programs culminating in an MBA, indicates an intention on the part of SETRHA to actively put in place the capabilities it requires to achieve its mission. A long-term impact is expected to be experienced from the development of a large cohort of managers within the region who share a common formative experience and a wide range of basic operational disciplines, and who are able to integrate their learning and experience in the practice of strategic management.

Piper, J. A., B. Muir, A. Stewart and J. Willetts (1997). "A common strategic language for clinicians and senior managers." Health Manpower Management 23(5): 155-158.

Abstract Effective strategic analysis of existing and potential services requires a framework which is relevant and understandable to both clinicians and senior managers. A framework is development based on analysis of services into four principal service streams: 1. emergency general hospital, 2. non-emergency general hospital, 3. specialist general hospital, and 4. tertiary. Relating service streams to clinical specialties provides a matrix which can provide a basis for an initial analysis of the current and prospective clinical services portfolio, allowing drilling down into the detail and back up to the overall picture. Portfolio effectiveness is assessed by considering overall viability consisting of three interrelated elements - clinical, market and financial viability. The inter-relationship of service streams, clinical specialties and viability allows the trust board and key clinicians to share insights into the current and potential systemic linkages between these three elements and to develop a vision of future strategic direction.

Preston, D. and J. Loan-Clarke (2000). "The NHS manager. A view from the bridge." Journal of Management in Medicine 14(2): 100-108.

Abstract The changing role of the manager has been a growing area of both academic and popular literature over recent years. In addition, the interest of the popular press has made terms like "grey suit" and "fat cat" common terminology. Management roles and managerial authority within today's organisations have seen many changes. This has led to frustration and anxiety for managers as they have watched their role change. In the NHS, like other sectors, managers have become a target for organisational redundancies and have experienced increased responsibility, closer monitoring of performance and heightened job insecurity. This paper aims to offer a contribution to the empirical data on managers by investigating one group of NHS managers' own perceptions of how others see their role. The findings suggest that NHS managers are very aware of the largely negative perceptions that surround them but accept this as an integral part of their role.

Prideaux, G. (1991). Experts do not make good managers. 27th IHF Congress, Washington DC, USA.

Abstract It has often been suggested that the health professionals, who know about health care, are the ones who are in the best position to manage health services. However, to suggest this is to fail to make an appropriate distinction between the world of the health professional and the world of the manager. Competence in one world is frequently far different from competence in the other. The difference between the two worlds has been highlighted for me by work I have been undertaking in management development, part of which has involved assisting health professionals to make the transition into management roles.

Prideaux, G. (1993). "Making the transition from health professional to manager." Australian Health Review 16(1): 43-49.

Abstract Health professionals who make a career change into a managerial role frequently find that the adjustment is a difficult one. Often they are not well prepared for the new role. They find that the world of the manager is different in a number of ways from the professional world they have known, and the skills required for effective performance are also different. This preliminary study, which involved interviews with a number of professionals who have made the transition, highlighted the adjustments they had to make and the transition difficulties they experienced. Attention is drawn to a number of ways in which health professionals can be assisted to develop into effective managers.

Roemer, M. I. (1993). "Higher education for public health leadership." International Journal of Health Services 23(2): 387-400.

Abstract The primary health care approach to public health stresses recognition of economic, political, and social determinants of health. In practice, briefly trained community health workers provide people with education and

health care, but they require sound supervision. Such tasks of leadership require higher education. This demands more schools of public health of independent status, as well as stronger departments of community medicine within schools of medicine. Independent schools of public health throughout the world are much stronger than preventive medicine departments in medical schools, as measured by full-time faculty, scope of teaching and research, and candidates enrolled. To train properly for leadership, such independent schools in the developing world should be multiplied by 12 times to meet the needs. Leadership required basic preparation in the full scope of public health knowledge, along with skills of effective management.

Salvage, J. (1991). "Making the best use of nursing skills: managers and clinicians in partnership." Journal of Management in Medicine 5(1): 54-59.

Abstract The issue of workforce planning in nursing is explored. The problem of nurse shortages and how this might be met are addressed. The concept of skill mix in nursing is discussed and the ramifications clarified. It is noted that the most effective means of dealing with workforce planning is not by applying complex systems designed by others but by involving the staff themselves in solving the problem. The importance of making nursing staff feel valued is stressed. A case study outlining the development of quality cycles in an elderly persons' unit is described.

Sanford, C. (1991). "Making the move from clinician to manager." Hospital Topics 69(4): 25-26.

Abstract From the outside, management doesn't look like so difficult a job: schedule a few employees, attend a few meetings. From the inside, however, it's a different story, especially when it is the "inside" of the manager that determines managerial success. Although the author addresses clinicians who are interested in management, she has words of wisdom for all future and current managers.

Scholten, G. R. M. and T. E. D. van der Grinten (1998). "Between physician and manager: new co-operation models in Dutch hospitals." Journal of Management in Medicine 12(1): 33-43.

Abstract Health care in The Netherlands can be located somewhere in between the different approaches of the US and the UK. The integration of the traditions of self-governance and private exploitation of services in a rather socialized and government-dominated system offers a typical context for the specialist-management relation in health care (van der Grinten, 1997). This context is a complicated mosaic of a multitude of interests and power positions that tend to make for conservatism within the system. But, at second sight, change does occur. Rather than being the result of a clear-cut policy, however, change is the outcome of a more evolutionary process in which new ideas are absorbed and intermingled with existing conceptions and vested practices.

Scholten and van der Grintin analyze the way hospital organization models handle the relationship between medical specialists and hospital management. All models that have been developed during the last ten years seek to integrate the medical specialists in the hospital organisation by formally subordinating them to the hospital management. However, recently a new model has come to the fore - the "co-makership" - in which the hospital management and the medical specialists are assigned a position alongside each other.

Shortell, S. M. (1990). "Revisiting the garden: medicine and management in the 1990s." Frontiers of Health Services Management 7(1): 3-32.

Abstract Although the importance of effective hospital-physician relationships is acknowledged by all, few empirically based guidelines exist for strengthening such relationships. Based on an in-depth examination of 10 sites' experience, a number of approaches for forming more effective hospital-physician relationships in the 1990s is suggested. Some of the issues addressed are focusing on hospital-physician collaboration and competition, embracing risk, forging new forms of partnership, creating value for purchasers, and molding younger physicians for leadership roles. Collins notes the importance of establishing a partnership that goes beyond the hospital and physicians to the community health system as a whole. Ross is troubled by the pervasive financial incentives in the system to maximize income and the strain that contraints place on the hospital-physician relationship. Ross' model emphasizes a common mission, an integrated medical staff, a pooling of financial risks between hospital and physician, and a unified governance and management structure. Schneller concentrates on the implications of the "age of the smart machine," which will revolutionize the medical environment and require redesign of roles and a new set of skills.

Sibbald, W. J. and A. Lynch (1990). "An ethical dilemma for the clinician-manager." Dimensions in Health Service 67(4): 15-17.

Simpson, J. (1993). "BAMM clinical directorates survey." The Clinician in Management 2(4): 13-15.

Abstract Over a 6 month period in 1992, information was collected from a sample of Clinical Directors by a detailed questionnaire. The questionnaire had been drawn up by BAMM, and had been piloted intensively prior to distribution. It is clearly acknolwledged that the sample of CSs in addition to being small, was taken from the then BAMM membership, and therefore mus be acknowledged as reflecting an enthusiasm for the concept of the involvement of clinicians in management. 110 questionnaires were issued of which 64 were returned.

Smith, P. (1992). "Consultants in management training: learning and doing." Journal of Management in Medicine 6(2): 11-26.

Abstract Reports research by interview into the effectiveness of management training for 40 medical consultants in two business schools which indicates that while learning during the business schools' programmes was mostly approved of, subsequent application of that learning has been more limited. Training can be made more effective by preparation before a programme, high key management of the stages and progress of training, an effective partnership between purchasers and providers of programmes, and clear support and expectations from managers.

Smith, A. (1993). "Management development evaluation and effectiveness." Journal of Management Development 12(1): 20-32.

Abstract Designing a management development evaluation along traditional lines has difficulties. An innovative methodology, which is user friendly to the practitioner, has been developed and piloted in the UK. The instrument takes the form of a structured diary, which delegates receive prior to the program. At specified intervals throughout the time period, entries are made which are copied and returned to the evaluator. A diary evaluation followed a key group of nurses through a period of immense change in a mental health services unit. Diarists were able to provide feedback to senior management via the evaluation, which was non-attributable. Nurses struggling with projects were identified and supported. The program achieved motivation throughout a period of change. The diary was felt to be useful as a time manager and to measure personal development. The organization has a system of individual performance review, and it was proposed to integrate the diary system into this.

Thomas, H. (2003). "Clinical networks for doctors and managers." British Medical Journal 326(22 March): 655.

Abstract Improved patient outcomes stem from decision making within multidisciplinary teams. Working effectively in teams is about building relationships and developing trust. Managed clinical networks are based on such teamwork, enabling doctors and managers to work together constructively. These networks link groups of health professionals and organisations from primary, secondary, and tertiary care, enabling them to work together in a coordinated way, unconstrained by professional and organisational boundaries to ensure equitable provision of high quality, effective services to patients. As my own network (in oncology) has developed, the leaders (including clinicians and managers) have emerged and enabled teams to improve delivery and quality of care across the network as well as in their individual organisations. Improvements have included closer working between primary and palliative care in the training of staff—for example, district nurses being trained in palliative care skills—and in developing a palliative care strategy. We all have a better understanding of the key challenges facing us and of our shared responsibility for tackling them. At their best, clinical networks offer flexibility, inspiration, and

mutual benefit. Communication, trust, and the development of longstanding relationships among major players all contribute to success.

Thorne, M. L. (1997). "Being a clinical director: first among equals or just a go-between?" Health Services Management Research 10: 205-215.

Abstract This article explores doctors' experience of the role of clinical director in a large National Health Service (NHS) teaching Trust. The advent of doctors in management, as a relatively new phenomenon in the NHS, is reviewed to provide a contextual setting for the case study. The empirical findings are presented as a clinical diamond which emerged as a form that captured the multifaceted nature of the role. The research demonstrates that, for a doctor, being a clinical director potentially threatens the professional identity, collegiality and autonomy of both the individual and the professional group the directorate represents. Moreover, stress that emanates from the structural tension inherent in the role is displaced into personal and professional stress. Clinical directors embody the tensions and conflicts of different managerial and professional cultures, whilst attempting to reconcile the demands being placed upon doctors who take on this role, and identifies the benefits and challenges that the role creates in leading health care. The final section identifies the issues that need to be considered to sustain this role in future and the recognition that it has substantially increased the power base of the medical profession, but often at a high price for the individuals involved.

Tietjen, C. (1991). "Management development in the NHS." Personnel Management 23(5): 52-54.

Abstract The immense changes currently taking place in the NHS are creating a grat many new demand for management deveopment, including turning doctors and consultants into effective managers. Corole Tietjen reports on the work being done by Yorkshie Health Authority and other bodies to meet these challenges, through initiatives ranging from development centres to MBAs, and on the related organisation development work.

Tjosvold, D. and R. MacPherson (1996). "Joint hospital management by physicians and nursing administrators." Health Care Management Review 21(3): 43-54.

Abstract The effectiveness of physician involvement in hospital management may depend on how physicians interact with nurses and administrators in management committees and other forums. The theory of cooperative and competitive goal interdependence is used to analyze problem solving between physicians and nursing administrators. It is hypothesized that physicians and nurse administrators with cooperative goals, compared to competitive or independent ones, discuss their opposing views openly and constructively and develop solutions that promote the effective delivery of quality health care and

strengthen their work relationship. Thirteen physicians and 13 nursing administrators from a major regional hospital in Greater Vancouver, British Columbia, participated in a study of how they worked together in management of the hospitals. Results largely support the hypothesized dynamics and outcomes of cooperative and competitive situations.

Tobin, M. (1993). "Transition from clinician to manager - a case study." Australian Health Review 16(1): 51-59.

Abstract The experiences of a group of five psychiatrists who made the transition from clinicians to managers in the Victorian Mental Health system are described. The paper reflects upon the action learning methodology for professionals in transition. Problems related to the painful gaining of experience, dissonance between the clinical and the management roles and the need to develop new rationalizations for understanding work are discussed.

Tobin, M. and J. Wells (1999). "Psychiatrists managing change: lost control or at a loss." Australasian Psychiatry 7(4): 194-198.

van der Grinten, T. E. D. (1997). "Changing management in health care." Journal of Management in Medicine 11(4): 209-213.

Viso, P. M. (1995). "Doctors, managers, and health services." The Lancet 345(8948): 522.

Walker, R. and P. Morgan (1996). "Involving doctors in management." Journal of Management in Medicine 10(1): 31-52.

Abstract Walker and Morgan report the results of a survey of 209 senior registrars and 269 consultants throughout Wales to identify the management development needs of doctors and ascertain their views of the value and utility of current management development course offerings in Wales. They find that, currently, management development for doctors in Wales is unstructured and uncoordinated but, despite this, many doctors, especially senior registrars, appeared keen to increase their future involvement in management and held positive views regarding management and management development. The questionnaire also required doctors to rank order six managerial topics and their elements: financial, human resource, strategic, operational, service quality and self-management. Of these, self-management issues were rated highest and there was some congruity in the rankings of the six topics by senior registrars and the other three consultant categories. Overall, managing a budget, medical and clinical audit, negotiating skills and leadership skills were ranked highest for inclusion in management development while project management, quality circles and equal opportunities received the lowest ratings.

Warren, R. (1994). "Doctor-managers and their performance as doctors." The Lancet 343(8913): 1641.

Washburn, E. R. (1998). "The physician leader as logotherapist." Physician Executive 24(4): 34-39.

Abstract Today's physicians feel helpless and angry about changing conditions in the medical landscape. This is due, in large part, to our postmodernist world view and the influence of corporations on medical practice. The life and work of existentialist psychiatrist Viktor Frankl is proposed as a role model for physicians to take back control of their profession. Physicians leaders are in the best position to bring the teachings and insight of Frankl's logotherapy to rank-and-file physicians in all practice settings, as well as into the board rooms of large medical corporations. This article considers the spiritual and moral troubles of American medicine, Frankl's answer to that affliction, and the implications of logotherapy for physician organizations and leadership. Physician executives are challenged to take up this task.

White, T. (1993). Management for Clinicians: a handbook for doctors and nurses. London, Edward Arnold.

Widell, J. A. (1997). "Making the transition from clinician to manager." Home Care Manager 1(2): 14-16.

Abstract The entire program provides a beginning orientation for the transition into a manager's position. The program focuses on basic skills and topics as well as provides the participant resources for continuing development. It is anticipated that the thought processes and viewpoints of a manager emerge during the discussions of class content. As the program evolves, other topics may be important to an agency. The program can be adapted to suit specific groups of managers, such as those in specialty programs or those working in branch offices. Ultimately, managers benefit from the interaction with others who encounter similar problems or concerns. It is highly recommended that each new manager also receive a peer mentor within the agency to ease the transition.

Willcocks, S. (1994). "The clinical director in the NHS: utilising a role-theory perspective." Journal of Management in Medicine 8(5): 68-76.

Abstract Reviews the role of the clinical director in the NHS, based on data collected in a qualitative research study. Utilizes role theory to invite insight into a relatively new but important managerial role. Suggests that effectiveness in the role may be measured by the extent to which managers are able to meet the expectations of their role set, and also that the overall effectiveness of the clinical direction may be the extent to which he or she is able to influence, adapt, modify or change these role expectations.

Willcocks, S. (1998). "The development of clinical management at an NHS trust hospital. A case study example." Journal of Management in Medicine 12(3): 168-177.

Abstract The article examines and comments on the development of clinical management at an NHS hospital Trust. It utilises a qualitative case study methodology to collect data from key stakeholders at this Trust. The data suggest some of the reasons why doctors may be receptive or non-receptive to the notion of clinical management. It recommends that attention is focused on the specialty context as a key factor in influencing the development of clinical management. It also suggests there may be other important factors, for example: training; the role of change agents; structure of clinical directorates; and individual factors such as cognition, attitudes and motivation.

Wilsher, P. (1993). "The mixed up manager." Management Today October: 34-42.

Abstract A survey was conducted by Management Today in association with the Institute of Management, which probed the minds of 989 UK managers to discover their hopes, fears, anxieties, and dreams for the future. More than 70% of respondents agreed that work-related anxieties were damaging their health, morale, and effectiveness at work and the quality of their home life. More than 80% complained bitterly of incompetent senior management, poor internal communications, time pressures, constant interruptions, and unrealistic business objectives. However, work for 82% of the respondents was a source of satisfaction, and fewer than 1/3 contemplated the lure of another job or a totally different career. Only a handful confessed to fearing downgrading or worse. Statistics provide little support for blind optimism, however. A shakeout in managers has occurred throughout the country, and in London and the Southwest, the managerial group accounts for more than 40% of the region's entire redundancy.