Review Article

Leadership, clinical freedom and cost-containment: lessons from recent history

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"There is a need to sustain the doctor-patient relationship and then build a new and mutually supportive doctor-manager relationship if the NHS reforms are to work".
Duncan Nichol, Chief Executive of the NHS (Nichol 1991).

Introduction

Public Health provision, free at the point of contact, is espoused in many countries within the European Union. The method of funding, whether by direct taxation, or via insurance companies, is not so much a problem as the ever increasing cost of medical advances and are. Clearly structures need to be in place to manage this service, and the modern doctor is called upon to play an ever-increasing role. The British National Health Service has served as a template for our local health service, albeit with various divergences along the way. This article highlights the central role of the doctor, as leader and manager, in effecting constant change within the service.

Leadership: The patient-doctor-management relationship

A successful hospital management can only bring about change when its clients, the general public, understand and endorse the professed goals of the health provider. The doctor plays a pivotal role in the patient-doctor-manager line of communication and enjoys a unique status enabling him or her to effect change. This fundamental principle is essential to any hospital management strategy and may be applied in various structures serving particular hospitals' needs. The spark that ignites change rests with the leader of the medical or surgical unit, and the catalyst for progress lies in the respect and confidence that he or she gains from patients. In a new venture, such as the Maltese Cardiothoracic Department, the starting point is necessarily protracted and arduous, but positive initial results, timely publicized, can feed positively into a doctor-patient population relationship that is mutually respectful and dependent.

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Thus armed with patient support, the doctor can subsequently give direction to the mission of the unit and, together with management, implement the changes that become necessary.

The doctor-manager relationship is the other integral and essential entity in the implementation of change. Cultural differences are at the root of potential conflict.[1] Inappropriate language may amplify traditional fears that management would infringe on professional independence. Thus terms such as "performance review", and "efficiency" conjure a dread of service curtailment. Similarly, describing the patient as a "client" or "consumer" transforms the concept of a noble vocation into a commercial venture. Managers realize that medical advances are relentless, may not fall in line with the general needs of the hospital, and inevitably tax resources. They face the unenviable task of demonstrating that clinical freedom and impulsive actions by consultants must be tempered with responsibility for managing these finite resources. Doctors are taught to give their patients the best possible treatment, irrespective of effort or cost. Managers, on the other hand, tend to suppress individual interests in their implementation of the organisational long-term mission, making optimal use of limited resources. Luckily these stereotypes are not widespread, and many doctors and managers share a mutual esteem for each other's respective roles. Setting out common goals avoids misunderstanding and strengthens the doctor-management axis within the framework of change. Incentives are important when implementing change. Thus, efficiency savings are more likely to ensue if they are reinvested within the same department. Doctors can materially help managers by explaining the impact that planned clinical improvement could have on resources. Conversely effective lines of communication from management can transform a doctor who is simply informed of a change to one who actively participates in the team bringing about that change. Managers, as leaders, must be respected if they are to be followed. Within the Public Health Service doctors have been described as the best, the brightest, the leaders,[2] a concept that was

embraced early on in the UK [3] and subsequently at the Johns Hopkins Hospital where doctors were actively involved in management.[4]

Early British National Health Service management structures

The Cogwheel reports[5] represented an early attempt at management organisation by specialties, involving senior and junior medical staff periodically auditing services and methods of provision. The first report (1967) proposed that Chairs represent their Divisions within the Medical Executive Committee, working closely with Nursing and Administration.[6] The second Cogwheel report (1972) was able to report success of this scheme with improved communication, a reduction in waiting lists and better management of financial resources.[7] The third report (1974) introduced the concept of District Management Teams (DMT) as the principal players promoting collaboration between the hospital and community services, emphasizing the role of efficiency and medical audit.[8] In an effort to slim down bureaucracy and speed implementation, the doctors' Executive Teams were introduced at hospital level in 1979.[9] Further reforms in 1982 saw representative consultants and general practitioners elected to the DMT's by their peers.[10] Hospital doctors' dissatisfaction with this new consensus management led to the Griffiths report and the recommendation for a "top doctor", as lobbied for by the British Medical association, a position that was embodied in the Medical Superintendent prior to 1974.[11] The British government took the recommendations on board in 1989 with a concerted effort to involve doctors more comprehensively in decision-making and resource management, in their policy of "working for patients".[12]

In his book entitled "The National Health Service: a political history", Charles Webster argues that "every restructuring intended to make it more efficient made it less so".[13] Aneurin Bevan's mission of a publicly funded system through taxation still provided the cheapest option, but crisis struck in 1979 after years of under-funding, over-management and industrial action.[14] The Thatcher years saw a concerted effort to limit costs with the introduction of prescription charges and the contracting out of services. Sadly costs rose relentlessly and the public's perception was overwhelmingly one of service cuts. Further policy changes resulted in the fragmentation of the NHS, with the introduction of GP fund holders, hospital trusts and the internal market.

Resource management and clinical freedom

Prior to 1948 doctors and their Superintendents were constantly aware of costs, whereas the new breed of NHS managers demonstrated less enthusiasm at cost-containment within a service that was "free" at the point of contact.[15] Although it was impossible for any advanced health service to provide all that was possible, this shortfall nevertheless had to be managed. During the first 30 years of the NHS more was spent every year as hospital managers attempted to fund the medical advances recommended by doctors. Following these years of plenty, 1979 was a year of realisation that the traditional methods of managing the NHS no longer applied. Cash limits dictated that, within an equitable system, each doctor had to be accountable for his or her actions, and this was partially achieved by involving doctors in resource management. Griffiths suggested that doctors' clinical freedom came with managerial responsibility, which meant that doctors were formally charged with liability for their decisions and were unequivocally accountable to their manager.[11] This system failed to reach its objectives because of indistinct management structures and too hasty an implementation.[16] Efficiency, as measured by an increased output with fixed resources, did not tackle the cash shortfall and was not rewarded. Henceforth the new objective would be savings.[17] Resource Management was a new initiative set up in 1986 that invested more power with doctors and nurses, at the same time introducing medical audit and benchmarking, comparing outcomes between diverse practices.[18] Doctors were to fill the new posts of Clinical Director (sometimes referred to as Clinical Chair), supported by a Business Manager and Nurse Manager. Whilst the remit for these new entities was comprehensive, including decentralization, communication, quality control and evaluation of outcomes, in many instances the primary motivation appeared to be cost reduction.

Clinical freedom is at the centre of health care provision. It assumes that autonomy in matters of clinical judgment and responsibility for patient care is not supervised by outside entities.[19] Members of the medical profession feel that they ought not to be managed by others outside their own profession. Politicians and managers have sought to curtail this autonomy in their quest to reduce costs. Various strategies including restructuring and redefining management roles have not guaranteed a more efficient health service. The main impedance to change is the fact that doctors are professionals, they are autonomous, and consequently they have not been significantly affected.

In 1983 Professor Hampton announced the death of clinical freedom.[20] He argued that the increasing influence of evidence-based medicine relegated individual practitioners to a subsidiary role in the clinical decision process. This view is not widely held in current practice where therapeutic options are chosen in the light of meta-

analyses and economic evaluations performed by bodies such as the National Institute of Clinical Excellence (NICE).[21] Clinicians are encouraged to keep abreast of guidelines and to apply them judiciously and appropriately to the individual patient who may share characteristics with a subset of a particular study population. It is just as important for clinicians to take heed of guidelines as it is for evidence-based medicine to embrace doctors' judgment, patients' needs and society's expectations.

Autonomy and management: The early years of the Maltese cardiothoracic program.

Prior to the establishment of the local cardiothoracic programme, patients were either sent for treatment to the United Kingdom, or were operated on in Malta by visiting UK teams. Doctors evaluated their patients for referral to foreign specialist units, and civil servants organized the travel arrangements for patients and visiting teams. The local referring doctors formed part of a board vested with the authority to send patients abroad. Decisions were corporate and there was no single Clinical Director in overall charge. The Hospital Administrator fulfilled the functions of a Business Manager and was in charge of communications with foreign entities, overseeing all the administrative work that made the program possible.

The established structures were utilized to set up and develop the local cardiothoracic programme. Prior to April 1995, local nurses travelled to the Northern General Hospital, Sheffield to gain work experience. The recently appointed local team performed the first forty operations in Malta in conjunction with four visiting by teams of anaesthetists and nurses from the same Sheffield unit. Subsequently the programme was run entirely by local staff except for a foreign perfusionist. The Administrator, under the direction of the Hospital Superintendent, provided all the necessary arrangements for these visits. As no Nursing Manager existed at the time, the Chief Surgeon collaborated closely with the Hospital Matron, both in strategic planning and in the day-to-day running of the programme. This nuclear Clinical Management team, borne out of necessity, and consisting of the Chief Surgeon, Hospital Administrator and the Hospital Matron, was the driving force behind the fledgling unit. In many ways the success of this team lay in the common goal of its participants: that of providing a comprehensive and high quality service to local patients without the necessity of foreign help.

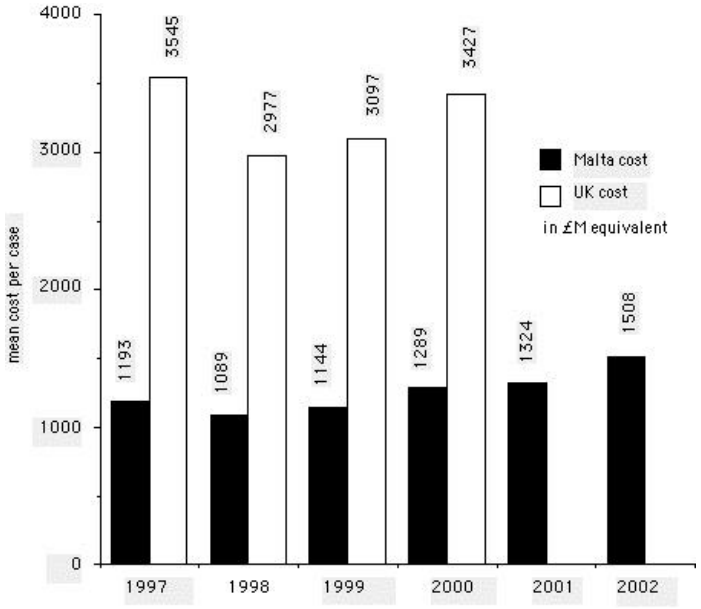
Cost reduction

The resources that had previously been allocated to treating patients abroad were a largely unknown entity. The new team quantified this cost and demonstrated substantial savings in a financial audit that was drawn up after the first years of service. [22] In doing so, the local programme fulfilled the goals of corporate responsibility as laid out in the Griffiths report, whilst preserving clinical freedom. An important goal of cost reduction was also achieved.

Comparing local costs with those in UK centres remains an inaccurate exercise. In 1999 Professor DJ Wheatly presented the cost of a cardiac surgery package at the Glasgow meeting of the Society of Cardiothoracic Surgeons of Great Britain and Ireland. The figure of £7021 (£M4560) for 1997 did not include any profit margin, which would be charged to a purchaser contracting out services. Health Care Navigator 2000 quoted the cheapest price for a private coronary bypass operation in the UK at £9500 and this yardstick was used for comparisons. [23] Yearly financial reports were compiled and presented to the health and finance ministers. During the first eight years 2813 cardiac operations were performed with estimated savings of £M10.3 million.[24] More recent cost comparisons for coronary surgery support our estimations. [25]

A cost-comparison exercise was carried out with UK NHS figures derived from information given in Parliament by Lord Hunt of King's Heath in reply to a question put forward by Lord Colwyn.[26] Trends were parallel but the UK cost was more than double the local cost (figure 1).

***Figure 1**: Cost comparison (UK figures for 2000 and 2001 not available)*



Discussion

The Maltese experience provides a management model that may be relevant to other start-up units in cardiothoracic surgery. Firstly by nature of its island status and high population density the Maltese model is relevant to small and medium sized units aspiring to function in a sustainable and independent fashion. The pillars of this model include a small but effective management structure, clinical freedom practiced within the constraints of expertise and services, and a mission to provide quality treatment in a patient-centred practice.

Leadership was initially provided by the surgeon and, with subsequent expansion of services, morphed into progressive tiers of management. Thus the embryonic command structure of chief surgeon, hospital administrator and matron, directing doctors, nurses and paramedics, subsequently lead to one comprising a chairman of cardiac services, answerable to a medical director, in turn reporting to the hospital chief executive officer. Nurses and paramedics, with separate professions in their own right, developed independent management structures, working alongside doctors, in many instances fulfilling roles and responsibilities of nurse practitioners.

The perceived constraints on clinical freedom were repeatedly challenged as diverse services were constantly introduced. The validation of this strategy was strengthened by public support for the programme coupled with the demonstration of substantial economic savings when compared with the cost of the previous overseas service. An important point of consolidation for the programme was the continued follow-up and support patients received after their surgical intervention. This continuity of care was not possible with an overseas visiting programme because of its inherent episodic nature and diverse teams. A corollary advantage was that of a rapidly growing support base provided by an ever-increasing cardiac population.

Clinical freedom translated into an expansion of services that would not have been possible within the constraints of larger health services. In contrast, the rationalisation of transplant units in the UK was driven by a perceived need to concentrate expertise within a few centres serving large catchment areas.[27] This policy not only limited the number of units offering this service, but, by way of the prevailing philosophy, discouraged any visiting team from offering this service to Malta. Soon after the establishment of the local programme, cardiac transplantation was performed successfully.[28] Similarly, other procedures that were offered by specialist centres, such as mitral valve repair and trans-catheter aortic valve implantation, were also performed locally, albeit in small numbers.[29] These examples illustrate that clinical freedom can flourish unabated when the machinery of bureaucratic constraint is under-developed. In the setting of an organisation such as the British National Health Service such diversity of services would not be sanctioned in a small unit.

Conclusion

Local experience supports a philosophy of keeping things simple and involving a small team of leaders with a common mission.

Sixty-five years after the establishment of the British National Health Service, lively debate and accelerated change are relentless. Although tremendous strides have been made in the delivery of a modern technological medicine, publicly funded health services are creaking under the weight of ever-increasing patient expectations in an ageing population. Long waiting lists and perceived inefficiencies are highlighted when public service provision is compared with various fabulously expensive private health care systems. Yet global life expectancy has increased from 48 years in 1995 to projected a 73 years in 2025. [30] Let us not underestimate the progress achieved.

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