Doctors and managers: a narrative literature review

Literature review
Alison Powell and Huw Davies

November 2016

There has been a longstanding policy agenda to improve services and reform clinical work by improving the working relationships between doctors and managers. Although areas of tension between the two groups have always been present, these relationships have been severely tested in the past three decades, which have seen multiple initiatives around quality and safety, successive reorganisations and major restructuring against a background of significant technological, clinical, social and demographic change. This narrative literature review looks at empirical studies on perceptions of doctor–manager relationships at medical director and clinical director level in the UK published since a 2002 survey on this subject by the same authors. This literature review accompanies a research report on the findings from a 2015 survey of doctors and managers at board and middle-management levels of NHS acute trusts, which seeks to understand their views on the current state of the relationship in the UK, the pressures it is coming under, how it has changed, and the outlook for the future.

The research report can be accessed at:
www.nuffieldtrust.org.uk/publications/doctors-managers

Contents

Executive summary

Background

There has been a longstanding policy agenda to improve services and reform clinical work by improving the working relationships between doctors and managers. Although areas of tension between the two groups have always been present, these relationships have been severely tested in the past three decades, which have seen multiple initiatives around quality and safety, successive reorganisations and major restructuring against a background of significant technological, clinical, social and demographic change.

A large survey of medical directors, chief executives, clinical directors and directorate managers carried out in 2002 (Davies and others, 2003a, b) found that areas of significant disagreement included the influence and involvement of clinicians in hospital management, perceptions of the quality of managerial staff, clinical confidence in management leadership and the balance between clinical and financial priorities. It is unsurprising that recent investigations into high-profile failures (e.g. the Francis reports of 2010 and 2013: Francis 2010; Francis 2013) and a series of policy reports making recommendations for future directions in quality and safety alike have continued to emphasise the importance of good working relationships between doctors and managers.

In preparation for new empirical work to explore the perceptions of doctors and managers about their working relationships in the current challenging context, we reviewed empirical studies on perceptions of doctor–manager relationships at medical director and clinical director level in the UK published since the 2002 survey.

Looking for evidence

- We used a range of sources including key databases, citation tracing and websites of relevant government and policy bodies and professional organisations. Reference lists of retrieved papers and reports were a key source of further material.

- A substantial part of the literature on doctor–manager relationships in the NHS consists of policy reports or commentary or review papers. We found few UK empirical studies (n=11) published in the period 2002–2015 that directly examined perceptions of doctor–manager relationships in secondary care in the NHS.

- However, we found additional empirical papers (n=17) on related topics (e.g. clinical leadership) that indirectly shed light on perceptions of the relationship. The key empirical studies are listed and summarised in a technical appendix, which is available from the authors upon request. We also drew on international studies where appropriate.

- Our reading and analysis of the studies prompted us to compile a list of six inter-related themes. We report here in this executive summary the key findings as they relate to each of the six themes.

Key findings from the empirical literature

Are relationships between doctors and managers improving or getting worse?

Whether relationships between the two groups are improving or deteriorating overall is difficult to assess; there are examples of effective working but much of the empirical

work continues to show frustrations and tension between doctors and managers and a lack of optimism that relationships will improve in the future. It is generally accepted that although there have been some shifts in the power balance between doctors and managers, overall doctors continue to be a powerful group which retains considerable clinical autonomy.

Do doctors and managers see each other as sharing the same perspectives?

Empirical work suggests that managers and doctors have different perspectives on their own work and on that of the other group, with managers tending to have a stronger organisational focus and doctors a stronger individual and group identity. Although there are areas where they share the same views (e.g. around a resentment at the intense politicisation of the NHS and the frequent 'interference' by government, and an ambivalence around embracing the managerial role), open acknowledgement of these shared values and concerns is relatively rare and the more negative perceptions between the two groups are often resistant to change.

How do managers manage doctors?

In general, NHS managers (in common with managers in other health systems) find doctors a challenging group to manage. NHS managers lack the positional power that managers in other sectors have and describe needing to use a range of strategies to engage doctors' support at board and directorate level. Such strategies include using other doctors to secure medical support, deliberately securing agreement in public on decisions and adopting a highly pragmatic approach to selecting the battles to be fought.

How do doctors respond to being managed by general managers?

The past three decades have seen a range of measures aimed at increasing managerial control over health professionals including doctors. Although outright clashes between the Department of Health and medical professional bodies have been seen, once at the implementation stage overt 'resistance' is less likely than more subtle forms of resistance by which doctors seek to uphold clinical autonomy despite managerial initiatives. Three broad types of strategy have been identified: eroding aspects of the managerial system (e.g. by not using guidelines or protocols); co-opting managerial tools into professional work and adapting them in ways that maintain clinical autonomy; and critiquing managerial initiatives (e.g. by arguing that available data are flawed). It is debated whether these forms of resistance (and the co-option strategy in particular) are resulting over time in the incorporation of some 'managerial' values and practices into the definition of medical professionalism.

How do doctor–managers bridge these divides?

In general, doctors have been reluctant to embrace managerial roles; many clinical directors in particular have struggled with limited opportunities for management training and limited access to the management decision-making processes within their organisation. The majority of doctor–managers maintain a clinical role and emphasise strongly their continued allegiance to that professional group. Despite this, many doctor–managers find it hard to act in a managerial capacity towards other doctors and perceive that they are seen by their peers as having 'gone over to the dark side'. The expectations of policy-makers that involving more doctors in management will mean a greater degree of management control over other doctors may be unduly optimistic.

Does the policy context shape relationships between doctors and managers?

The policy context has a very important influence on doctor–manager relationships in the NHS. Four features that the research suggests have been particularly influential in the past decade are: the substantial and high-profile political critique of NHS management and managers; the organisational turbulence created by successive major reorganisations against a background of financial pressures; the continuing policy trend towards reducing medical autonomy; and the intense and demanding nature of NHS management roles. In combination these policy developments have created an environment in which both managers and doctors have felt beleaguered and under attack from politicians, the media and the other group, and have struggled to fulfil their professional roles. This has meant that, both at a collective and a local level, neither group has had the resources to devote to improving their working relationships, despite recognition on both sides that improvements are needed.

Current developments

The empirical studies in the UK at medical director and clinical director level published over the past decade or so bear out the observations of the 2013 Francis report and the 2015 Institute of Healthcare Management survey that relationships between doctors and managers continue to be challenging. Whether these tensions constitute a 'gulf' between the two groups is debatable, but significant challenges are widespread. It is important to note that there is no uniform pattern to these relationships and that the 'collective' level of much of the research may be obscuring some important differences within individual hospitals and departments.

Almost half of the manager respondents in the 2015 Institute of Healthcare Management survey thought that individual clinicians and managers have a responsibility to make changes to improve these relationships; it is arguable that responsibility is both individual and collective, and that macro-level political changes are also needed, including a greater respect for the importance of organisational stability.

There has been a major policy drive in the last five years, endorsed by the medical profession, towards 'clinical leadership' as an integral role for all doctors. Although it is too soon to assess the full impact of this, this policy direction has been criticised for being under-developed and for failing to pay attention to the existing evidence on leadership. The implication that 'management' has failed and that 'clinical leadership' is the solution seems unlikely to transform relationships between doctors and managers.

A range of approaches to improving doctor–manager relationships have been suggested over the past decade. Central to many of these are an emphasis on facilitated dialogue and conflict resolution together with an emphasis on seeking alignment and collaboration on shared organisational problems rather than a melding of the two distinct identities. An important strand of improving doctor–manager relationships will be to improve relationships between medical managers and their clinical colleagues, in part by enhancing the status and support given to medical management roles.

Concluding remarks

Considering the importance of the doctor–manager relationship to the delivery of high quality health care services and the high political profile of this issue, we found relatively few UK empirical studies on perceptions of doctor–manager relationships published in the past decade. The forthcoming UK-wide survey of doctors and managers at board and directorate levels is likely to prove a useful addition to the field.

1. Background

There has been a longstanding policy agenda to improve services and reform clinical work by improving the working relationships between doctors and managers (Harvey and others, 2014). Relationships between doctors and managers have been central to the delivery of health care services since the inception of the NHS (McKee and others, 1999; Snow 2013) and tensions between the two groups began to appear much earlier (Arndt and Bigelow, 2007). These relationships have been severely tested in the past three decades in which the service has faced successive reorganisations and major restructurings against a background of significant technological, clinical, demographic and social change (Harrison and Lim, 2003; Blackler, 2006).

It is not surprising that there are tensions. Modern health care organisations are highly complex and challenging to manage (Blackler, 2006). They have been described as operating between two metaphors: that of a production-engineering firm and that of a human enterprise (Bohmer, 2012). As complex organisations, many if not most NHS organisations have a culture of tribalism (Fitzgerald and others, 2006; Greener and others, 2011; Spurgeon and others, 2011) and two key groups that are often seen as operating in different ways are doctors and managers (Klaber and others, 2012). Furthermore, the NHS operates in a highly challenging external environment with intense media and political scrutiny (Harvey and others, 2014).

Earlier survey work on perceptions of doctor–manager relationships

Just over a decade ago, empirical work in the NHS with a large sample of doctors and managers showed some areas of agreement between doctors and managers but also found other areas on which their views diverged markedly (Davies and others, 2003a, b). There was agreement around the overall organisational goals and the high quality of medical staff. There was also good agreement that managers allowed doctors sufficient autonomy to practise medicine effectively and that clinical performance data could stimulate good practice and strengthen service management (Davies and others, 2003a, b). However, views also diverged in significant ways: senior non-clinical leaders were more optimistic about doctor–manager relationships than senior clinical leaders, and both of these groups were more positive than operational managers, whether clinical or non-clinical (Davies and others, 2003a, b). Touchstones of discontent included: the influence and involvement of clinicians in hospital management; perceptions of the quality of managerial staff; clinical confidence in management leadership; and the balance between clinical and financial priorities. Communication and resourcing issues also often provoked significant disagreement (Davies and others, 2003a, b).

The implications of poor working relationships for quality of care

Investigations into high-profile safety and quality failures have often pointed to poor communication and a lack of trust between doctors and managers as one of the root causes (Garelick and Fagin, 2005; Kirkpatrick and others, 2008; Klaber and others, 2012). High level reports to the Darzi review in 2008 (Institute for Healthcare Improvement, 2008; Joint Commission International, 2008; McGlynn and others,

2008) pointed to evidence of significant rifts between doctors and managers in the NHS and emphasised the fundamental importance to the quality and sustainability of NHS services of addressing and healing this core relationship.

The King's Fund Commission on Leadership and Management in the NHS (2011) described as a major weakness the failure of the NHS to encourage the involvement of health professionals, and particularly doctors, in management and leadership in a sustained way (The King's Fund, 2011). More recently, the 2013 Francis report, seen as a watershed for the NHS in facing up to care deficiencies, emphasised the centrality of good working relationships between clinicians and managers:

> Clinicians must be engaged to a far greater degree of engagement in leadership and management roles. The gulf between clinicians and management needs to be closed.
> *(Francis, 2013: volume 3, p.1545)*

But how have doctor–manager relationships changed over the past decade since the earlier large-scale survey in 2002? What do we know from empirical studies carried out in the NHS since then?

Looking for evidence

We carried out a rapid narrative review of the main strands of recent empirical and theoretical work on doctor–manager relationships at 'senior executive' (board/medical director level) and at 'senior operational' (directorate management/clinical director level) conducted since the 2002 survey. We summarise our approach briefly here; a more detailed account of our methods can be found in the technical appendix, which is available from the authors upon request.

- We used a range of sources including key databases, citation tracing and websites of relevant government and policy bodies and professional organisations. Reference lists of retrieved papers and reports were a key source of further material.

- A substantial part of the literature on doctor–manager relationships in the NHS consists of policy reports or commentary or review papers. We found few UK empirical studies (n=11) published in the period 2002–2015 that directly examined perceptions of doctor–manager relationships in secondary care in the NHS.

- We also found additional empirical papers (n=17) on related topics (e.g. clinical leadership) that indirectly shed light on perceptions of the relationship.

- The key empirical studies are listed and summarised in the technical appendix.

- Because of significant differences in contextual factors (e.g. the structure, governance, financing, historical development and management of health care) in different countries, even in Europe (Bode and Dent, 2014), there are limits to the parallels that can be drawn between doctor–manager relationships in the UK and studies outside the UK. We therefore focused primarily on UK studies. Nevertheless, at times in this review we draw on non-UK studies to illustrate a specific point or to highlight a gap in the UK literature.

2. Key themes in the literature on doctor–manager relationships

Our iterative reading of the literature on doctor–manager relationships from 2002–2015 prompted us to develop a set of six inter-related themes:

1. Are relationships between doctors and managers improving or getting worse?

2. Do doctors and managers see each other as sharing the same perspectives?

3. How do managers manage doctors?

4. How do doctors respond to being managed by general managers?

5. How do doctor–managers bridge these divides?

6. Does the policy context shape relationships between doctors and managers?

These six themes provide a helpful framework for understanding what the literature shows about how the doctor–manager relationship at medical director and clinical director level has been perceived in NHS secondary care. The following sections of the review take each of these themes in turn to see what is known about each of them in the NHS context.

Are relationships between doctors and managers improving or getting worse?

> The physician memory of difficult hospital interactions is often very long. *(Reinertsen and others, 2007, p. 6)*

Evidence of contemporary concerns and an overall narrative of continuing challenges

There is little evidence that the troubled relationships between doctors and managers described over a decade ago have improved markedly. One international report to the Darzi review in 2008 pointed to evidence of a significant gulf between managers and doctors (Joint Commission International, 2008) while the Institute for Healthcare Improvement report to that review (2008) suggested that the gulf between the two groups was actually growing.

More recently a survey by the Institute of Healthcare Management (2015) found that nearly three quarters of managers thought that the relationship between managers and clinicians could be defined as 'a partnership with areas of tension' or 'a relationship of tolerance with frequent tensions'. Nearly three quarters thought that the relationship would not improve or would get worse over the next five years. A further 14%

described it as a relationship with 'persistent and unresolved tensions'. It seems that the tensions uncovered earlier remain just as persistent today.

In general, many doctors continue to express a low regard for managers and perceive that they fail to show sufficient respect to medical staff (Marshall, 2008; Brown and others, 2011; British Medical Association, 2012). Managers are often perceived by doctors as failing to acknowledge clinical expertise, clinical responsibilities or the importance of the clinical perspective, and of failing to recognise that doctors are already making efforts to improve the quality of care (Levenson and others, 2008; Kippist and Fitzgerald, 2012; Lipworth and others, 2013; Rodrigues and Bladen, 2013). Moreover, interactions between doctors and managers are often characterised by defensive and oppositional behaviours (MacIntosh and others, 2012) and by 'strategic' behaviour which seeks to achieve particular goals through impression management and other strategies (Greener, 2005).

Conflicts between doctors and managers are cited as one of the challenges that doctors in management grapple with (Ireri and others, 2011) and are perceived as one of the factors acting as a disincentive to doctors who might be considering going into management roles. Both groups tend to stereotype the other as 'management' or as 'clinicians' or 'consultants' and to generalise about their behaviour (e.g. Hoque and others, 2004; Klopper-Kes and others, 2009). A study in Dutch hospitals (Klopper-Kes and others, 2009) found that managers saw doctors as stubborn, ruthless, arrogant and convinced of their superiority over other groups. In turn, doctors characterised managers as poor leaders who were determined to 'push the limits' as far as possible and who were unaware of what was important to doctors. Managers report frustration at dealing with consultant managers who see themselves as autonomous and not part of the management structure and with medical clinicians who present a major barrier to change (Hoque and others, 2004; von Knorring and others, 2010).

Doctors and managers often agree that they do not trust each other, that they communicate poorly, and that they fail to agree on shared goals (Reasbeck, 2008). Many doctors (and in some cases managers too) have little confidence in the calibre of management staff (Vlastarakos and Nikolopoulos, 2007; Reasbeck, 2008). Hospital doctors are often very critical of NHS managers, particularly those who do not have a clinical background and relationships between managers and doctors are frequently adversarial and hostile (British Medical Association, 2012). Doctors suggest that there are too many managers in the NHS and that managers have gained power from the loss of clinical autonomy (Reasbeck, 2008). Many managers and clinicians, especially those below board level, consider that the quality of NHS leadership is improving but that it remains poor or very poor (The King's Fund, 2014).

Some doctor–managers and managers perceive relationships between them as generally sound but distant (Fitzgerald and others, 2006). Many clinical directors report feeling excluded from the main decision-making processes in their organisations (Forbes and Hallier, 2006; Guven-Uslu, 2006; Giordano, 2010); such relationships may not be openly dysfunctional but may impair effective working if doctor–managers and managers are effectively working in parallel rather than together.

Some examples of effective working

Many doctors express the view that greater partnership working between doctors and managers would be helpful, and some believe that attitudes are beginning to change

(Levenson and others, 2008) and that a 'them and us' culture is diminishing (e.g. Hoque and others, 2004). It is argued that the historical stereotyping of adversarial relationships between doctors and managers may obscure some strong working relationships which are characterised by mutual respect (Snow, 2013), and that research which looks at 'doctors' or 'managers' at a collective level may fail to show the variations that exist between different organisational contexts and sub-groups (Hallier and Forbes, 2005; Byrkjeflot and Jespersen, 2014). Some suggest that attitudes are changing, particularly as a new generation of junior doctors goes through who have no experience of practising in the era of the Griffiths reforms and subsequent changes to the management of the NHS and who have always worked in a culture of data and targets; it is suggested that this generation may be displaying a 'maturing' approach to both managers and the corporate agenda (Nicol and others, 2014). Indeed there are examples of effective working between clinicians and managers (McKee and others, 1999; Fitzgerald and others, 2006; Kirkpatrick and others, 2008; Dickinson and others, 2013a, Harvey and others, 2014), and much may be learnt from these. However, such positive examples are often commented on by other staff, suggesting that they may be relatively unusual or noteworthy (Fitzgerald and others, 2006; Kirkpatrick and others, 2008).

Even those organisations that are recognised as being frontrunners in engaging clinicians and developing partnership working between managers and clinicians acknowledge that embedding this culture throughout the organisation has not yet been achieved (Clark and Nath, 2014). It is likely that the picture is variable: relationships between individuals and between groups of doctors and managers in hospitals may vary depending on factors like the specialty, the size of the organisation, and the span of responsibility that the doctors and managers have (Harvey and others, 2014). Some doctors may view management in general with suspicion but work well with the specific managers in their department (Harvey and others, 2014). They may also value some parts of the managerial work if not all: for example, clinical directors in one study acknowledged the role that middle managers played in protecting them from the demands of senior managers (Harvey and others, 2014).

Widespread perceptions that, overall, doctors retain a high degree of clinical autonomy

A range of policy measures over the past three decades have sought, explicitly or implicitly, to reduce the power of the medical profession and to enhance the role of NHS managers (Som, 2005; Numerato and others, 2012). More recently, there has been a strong policy drive to increase the involvement of doctors in leadership (discussed on p. 23 onwards). Some authors (e.g. Turner and others, 2013) suggest that a degree of hybridisation between professional and managerial cultures has occurred as a result. However, most commentators agree that despite these measures, despite the annexation of aspects of the biomedical model to managerial control (Harrison, 2009), and despite the complex and contested nature of power in organisations (Macfarlane and others, 2011), the power balance between doctors and managers has shifted little and that doctors retain a considerable degree of power and influence in the health service (Hallier and Forbes, 2005; Currie and Suhomlinova, 2006; Ackroyd and others, 2007; Ham and Dickinson, 2008; Baker and Denis, 2011; Greener and others, 2011; Numerato and others, 2012; Dickinson and others, 2013b). Nevertheless, there is a strong discourse among many doctors about the extent to which managers have disempowered them over recent decades.

Taken together then, recent empirical work shows that relationships on the ground remain troubled and challenging; whether relationships between the two groups are improving or deteriorating overall is difficult to assess. Despite some areas of success, it is clear that there are large numbers of doctors, managers and policy-makers who believe that significant challenges remain.

Do doctors and managers see each other as sharing the same perspectives?

Doctors and managers often see each other as very different

Typically, clinicians and managers are seen as inhabiting different worlds. These are typically characterised as the worlds of 'cure' and 'control' (Baathe and Norback, 2013): the professional/clinical culture and the managerial/corporate culture (Dalmas, 2012). In another categorisation the hospital has been described as not a singular organisation but four interacting 'worlds': those of 'cure' (medicine); 'care' (nursing); the administrative or management world; and the world of the trustees or board (Eeckloo and others, 2007). This is said to lead to four sets of activities, ways of organising and mindsets, with only semi-permeable 'walls' between them.

Doctors and managers are seen as having been trained and socialised in different ways (Garelick and Fagin, 2005; Greener and others, 2011; Klaber and others, 2012; MacLeod, 2012; Kaissi, 2014); indeed, the socialisation process for doctors is intense and prolonged, which may result in a more ingrained professional culture (MacLeod, 2012). Managers generally achieve promotion through the development of competency in managing in the workplace, while doctors tend to reach management positions through excellence in other fields (e.g. clinical work, teaching and research) (Klaber and others, 2012). Doctors are seen as focusing on clinical care and on the needs of individual patients (Levenson and others, 2008; Neogy and Kirkpatrick, 2009; Snell and others, 2011) – i.e. following a 'medical logic' – while managers are seen as valuing 'managerial logic' – i.e. one more concerned with resources and targets (Guven-Uslu, 2006; Scarparo, 2006; Dwyer, 2010; Klaber and others, 2012; Martin and others, 2015). The types of language managers and doctors use may differ (from technical vocabulary, to shorthand and jargon) and they may show preferences for different types of evidence, with clinicians typically favouring largely quantitative data and managers including qualitative data within the evidence they consider (Klaber and others, 2012).

Doctors often see managers as geographically distant from the frontline as well as detached and distant in their values (for example, unable to engage in the realities of patient care or unable to see the patient's perspective (Storey and Holti, 2009)) while managers often see doctors as unrealistic about funding constraints (Dalmas, 2012; Martin and others, 2015). Doctors often think that managers have a very limited understanding of clinical responsibilities, but doctors may also acknowledge that they themselves have little understanding of managers' roles and responsibilities (Rodrigues and Bladen, 2013).

Doctors and managers sometimes see each other as opponents and behave accordingly

Conversations between doctors and managers suggest that they often see each other as opponents pursuing different goals. The conversational styles that individuals from the two groups typically adopt are (consciously or subconsciously) aimed at bolstering the identity of the individual's own group and have the effect of reinforcing distance

and opposition between the two groups (MacIntosh and others, 2012). Doctors and managers are very aware that doctors have high professional status and higher standing than managers (Degeling and others, 2001; von Knorring and others, 2010). However, they disagree about who has most power within the organisation: ironically, each group believes that the other group has most power (Klopper-Kes and others, 2009; MacIntosh and others, 2012; Martin and others, 2015).

A background of distrust may undermine initial encounters between doctors and managers from which it may be difficult to recover and reach common ground (Garelick and Fagin, 2005). This may be compounded by the tendency to network with members of their own professional group: individuals then may have little exposure to other perspectives (Fitzgerald and others, 2006; Martin and others, 2015). It may also be compounded by the shifts between these worlds that have been occurring. Such shifts are destabilising for those who are accustomed to the status quo, and many therefore resist such changes. For example, the emphasis on rationalising clinical practice inherent in evidence based medicine increases the scope for managers to view and seek to change the clinical worlds of care and cure, while the increasing emphasis on clinicians taking on management roles shifts the boundaries between the cure/care and management worlds (Eeckloo and others, 2007).

These perceptions of difference have some empirical justification

Managers and doctors do indeed appear to have some differing characteristics, with doctors having a stronger culture of individual responsibility and accountability and a stronger need for peer recognition (Taylor and Benton, 2008). In terms of their orientation within the service, doctors generally feel a much stronger personal responsibility for the quality of care than they do for financial issues within the service (Hoque and others, 2004; Dickinson and others, 2013b). Many doctors derive significant professional fulfilment from their clinical work and may find this sufficient: they may not look for a sense of belonging to the organisation (Baathe and Norback, 2013) and so may feel detached from managers and from an organisational orientation.

Traditionally doctors have seen themselves as autonomous and as independent of organisational structures (Neale and others, 2007). Several characteristics of the 'medical mindset' may make relationships with managers more challenging (Garelick and Fagin, 2005; MacLeod, 2012; Kaissi, 2014). These include doctors' orientation to the treatment of individual patients and their strong sense of personal accountability for the care that they provide, which may distance them from those who do not share or appear to understand this (often onerous) responsibility. Doctors also share a strong sense of collegiality towards other doctors, which may distance them from other groups. The medical approach to evidence, which typically combines a respect for scientific data with a strong influence from what individuals have seen and experienced (Reinertsen and others, 2007) may be different from that of managers who may favour both greater standardisation and a broader definition of what constitutes 'evidence'. Thus, managers and doctors sometimes display a lack of respect for (and understanding of) the information used by the other group (McGlynn and others, 2008).

Managers are more likely than doctors to see themselves as interdependent professionals with an organisational identity, whereas doctors may privilege their professional identity and see themselves as independent professionals (Kirkpatrick and others, 2012; MacLeod, 2012). Managers are socialised to expect to share responsibilities and to expect to tolerate multiple, insoluble problems; medical training

may predispose doctors to be independent and competitive and to approach problems as soluble using the 'scientific approach' (Garelick and Fagin, 2005; MacLeod, 2012). Doctors typically tend to believe in personal responsibility for quality of care and may struggle with the 'systems perspective' endorsed by much of improvement science (Berwick 1996; Reinertsen and others, 2007); they may therefore resist managerial initiatives that use this approach.

Managers and doctors often disagree on the importance of a range of aspects of organisational culture (Klopper-Kes and others, 2010), including: doctors' autonomy; the degree of trust in decisions made by the board of directors; the degree of medical engagement in their organisation (Spurgeon and others, 2008); and the need for open discussion of clinical failures. They may also differ in their perceptions of current practice around quality and safety (e.g. Klopper-Kes and others, 2010) and on definitions of 'quality' (Wiig and others, 2014). In addition, both groups may seek to define organisational problems in ways which identify their own group as essential to solving the problem (Fitzgerald and others, 2006).

Perceptions of 'fairness' in the provision of health services also differ between doctors and managers: doctors are more likely to consider individual patients while managers are more likely to consider what is fair in relation to populations of patients (Fitzgerald and others, 2006). This has been labelled as 'the problem of the apostrophe', with doctors typically seen as acting as the patient's advocate and managers acting as the patients' advocate (Plochg and Klazinga, 2005; Kaissi, 2014).

Managers and doctors differ in their prescriptions for what is needed to improve the quality and safety of health care (Degeling and others, 2001; Degeling and others, 2006; Klaber and others, 2012): managers are more likely to favour changes that move services towards a more systematised approach, that increase team working and that balance clinical autonomy with greater transparency and accountability. Managers show stronger support than doctors for mechanisms to make the resource implications of clinical decisions more explicit (Degeling and others, 2003; Degeling and others, 2006; Morgan and Ogbonna, 2008; Greener and others, 2011). However, doctors with previous or current managerial responsibilities are more likely to favour 'control' systems than their clinical peers (Morgan and Ogbonna, 2008).

Doctors and managers share some key values but acknowledgement of these shared values is rare, and negative perceptions are often maintained even in the face of counter evidence

Doctors and managers do share some key values: for example both groups believe strongly that clinical need rather than ability to pay should be the determining factor for NHS services (Morgan and Ogbonna, 2008) and both groups are motivated in their choice of career by their desire to make a difference to people's lives (Waldman and others, 2006) and a stated concern to put patients first (Taylor and Benton, 2008). Consultants and those managers closest to service delivery rank quality as their primary goal over volume of care or financial objectives (Crilly and Le Grand, 2004). A public sector ethos rather than a performance ethos was dominant for the majority of clinical and non-clinical junior and middle managers in one recent study (Harvey and others, 2014).

There are empirical examples of consultants acknowledging the value of managers' roles and skills, recognising that many managers are overworked and under-appreciated (Moore, 2011); in particular, those managers with whom consultants work closely may

be perceived in more positive ways, compared to the senior managers on the board who may be perceived as remote from day-to-day clinical pressures (Moore, 2011). Efforts by managers to resolve minor but frustrating practical problems have been seen to improve doctor–manager relationships and may help to build trust between them (Moore and Buchanan, 2013).

Concern for integrity, trust and honesty in health services is shared by managers and doctors (Taylor and Benton, 2008; Osbourne, 2010). They also share a strong belief that there is too much intervention in health care from external agencies and in particular from the government (Morgan and Ogbonna, 2008) and frustration at the imposition of frequent changes by government and at the intense politicisation of the NHS (Taylor and Benton, 2008). Both agree on the importance of cooperation between doctors and managers but see this as difficult to achieve in practice. Clinical and non-clinical managers at a range of levels may also share some of the same pressures (Moore, 2011) and both may share a reluctance to embrace the managerial role: managerial identities may not be very robust (Harvey and others, 2014). However, acknowledgement of these shared values and concerns is rare and perceptions about the other group can be resistant to change; they are often maintained even in the face of counter-evidence (Martin and others, 2015).

How do managers manage doctors?

Managers adopt a range of strategies to manage doctors as standard line management processes are thought to be ineffective

In general, health service managers find doctors a challenging group to manage (Harvey and others, 2014). Managers often perceive doctors to be highly intelligent individuals who are well able to act strategically and to put aside competition between specialties and any managerial role they may have to use their professional status as clinicians to unite in the face of a common opponent (Greener, 2007). Doctors are in a unique position because unlike managers they have the potential to both provide and manage patient care (MacLeod, 2012) and it is still largely doctors who define medical care (Spurgeon and others, 2011): "*medicine remains an occupation with legislative and ideological backing for its claimed mandate to define … what constitutes knowledge and expertise in clinical work performance*" (Degeling and Maxwell, 2004, p. 121).

It has long been recognised that consultants in particular are in a powerful position to resist change and to undermine the implementation of initiatives that they oppose (Gollop and others, 2004) (Hoque and others, 2004): Many consultants have been sceptical about the sometimes transient application of what they see as 'management fads' in health care (e.g. Total Quality Management and Business Process Reengineering) (Gollop and others, 2004): "management here plays a modest facilitative role rather than a directive function and has, by itself, little power to impose radical change in respect of practices involved in the actual organization and delivery of care" (McNulty, 2003, p.S34).

Managers in health care organisations lack the positional power that managers in other types of organisations typically have and the mechanisms for controlling the performance of doctors largely sit outside the organisation, under the control of professional bodies (Bohmer, 2012). Instead managers have to use influencing and negotiating skills or to 'nag, moan or cajole' as one manager described it (Hoque and others, 2004). Those at middle-management level appear to find the challenge

particularly difficult: they may be those who most come into contact with clinicians and who face pressure both from clinicians and from their own senior managers (NHS Confederation, 2007). As a result, managers typically employ a range of strategies to manage doctors (Greener, 2005).

Health care managers in the UK have described this range of strategies (Mueller and others, 2003), including: the offer of personal or departmental incentives; allowing clinicians to claim credit for joint initiatives; and enlisting clinical 'champions'. Managers describe having to use a substantial degree of pragmatism and to perform a delicate mediating act, compromising on managerial objectives where necessary to avoid complete withdrawal of clinical support at board level (Mueller and others, 2003). Managers may use 'cautioning' scripts with other managers (i.e. reminding them of the power of consultants). Other strategies include using clinicians (e.g. clinical directors) to legitimise policies that may be unpopular with doctors (Thorne, 2002), 'hiding' improvement methodologies behind 'common sense' pilot experiments (Gollop and others, 2004), using informal one-to-one interactions and networking to 'win over' key individuals, and providing statistical and other data to emphasise the evidence base for proposed service changes (Harvey and others, 2014).

Managers may also seek to secure public agreement on decisions (to make it harder for doctors to go back on agreements) (Greener, 2007) and may work to maintain the outward appearance of continuing 'traditional' medical power even in circumstances where this has been eroded to some degree by shifts in power between managers and clinicians (Greener, 2007). At meetings, managers may mix 'sceptics' and 'enthusiasts' to allow peer pressure to influence doctors (Gollop and others, 2004), or use careful agenda-setting to keep off the agenda items that they perceive as likely to provoke open resistance from doctors (Greener, 2007).

There is evidence that the strategies chosen and their justification may differ according to the gender of the manager (Greener, 2005): in 'front-stage' (public) settings, male managers may justify their strategies in terms of 'winning' or 'beating the doctors' while female managers may emphasise 'getting the job done'. Avoidance is also a strategy that managers use: managers may decide not to propose changes that they anticipate will be opposed by doctors (Currie and Procter, 2005). These strategies are not unique to UK health service managers. Health care managers in Sweden (von Knorring and others, 2010) have described similar strategies including:

- organisational separation – holding separate meetings with doctors as multi-professional meetings often result in poor attendance by doctors

- nagging and arguing – a largely self-explanatory strategy

- compensation – providing incentives for participating in meetings

- relying on the physician role – enlisting a clinician to champion the ideas that the manager wanted to pursue.

In summary, NHS managers find doctors a challenging group to manage. NHS managers lack the positional power that managers in other sectors have and describe needing to use a range of strategies to engage doctors' support at board and directorate level.

How do doctors respond to being managed by general managers?

'Resistance' takes different forms but aims to protect clinical autonomy

Driven in part by broader changes in the public sector (e.g. the rise of 'New Public Management' (Kuhlmann and Von Knorring, 2014)) and by new challenges facing health services (e.g. high-profile clinical failures, the rapid spread of information to the public through changes in information technology), the past three decades have seen a range of initiatives aimed at increasing managerial control over health professionals, including doctors (Numerato and others, 2012; Bode and Dent, 2014). Such innovations are not neutral but are better seen as relational: that is, affected by interests and power relationships (van Wijngaarden and others, 2012). Doctors and other health professionals may therefore seek to resist innovations that appear to undermine or conflict with professional interests and objectives. These managerial changes have therefore seen a range of responses from doctors. Outright clashes have been seen at the macro level (i.e. between the Department of Health and medical professional bodies), but once at the implementation stage within organisations, overt 'resistance' may be less common than more subtle forms of resistance which nevertheless seek to uphold clinical autonomy (Numerato and others, 2012).

The past decade has seen a large number of policy initiatives around patient safety, clinical governance and quality improvement aiming to systematise and monitor professional practice (e.g. around professional appraisal and revalidation, reporting of adverse incidents, the adoption of single-use devices). A major strand of empirical work suggests that doctors have responded to these initiatives in a range of ways that provide subtle and diverse forms of resistance to managerial change and that seek to uphold doctors' clinical autonomy and freedom from managerial control (Waring, 2005; Som, 2005; McGivern and Ferlie, 2007; Waring, 2007; Currie and others, 2009; Waring and Currie, 2009; Saario, 2012). The strategies that doctors adopt to resist managerial changes fall into three broad types (Waring and Currie, 2009; Numerato and others, 2012; Byrkjeflot and Jespersen, 2014):

- eroding aspects of the managerial system (e.g. by not using guidelines or information systems)

- occupying strategic positions within the system (e.g. by co-opting managerial tools into professional work and taking the system over and adapting it in ways that maintain clinical autonomy, such as controlling the development or implementation of audit, or adapting protocols and guidelines to doctors' needs)

- critiquing the system (e.g. criticising the scientific evidence base underpinning the managerial measures or arguing that the available data are not robust (Guven-Uslu, 2006)).

More simply, doctors may also employ linguistic strategies to denigrate managers: for example, referring to managers as 'administrators' in order to ascribe to them a support role rather than one of leadership (Learmonth, 2005). Differing patterns of response to managerial initiatives are not just about doctors' initial attitudes towards them. The experience of clinical directors in one study showed that their experiences of being clinical managers and in particular the marked clash between their expectations of a mutual role with management and their experience of being kept 'at arm's length'

contributed to their subsequent response to such initiatives and to the degree with which they embraced managerial values and practices in their own roles (Hallier and Forbes, 2005).

Although for simplicity we have separated out our observations on how managers manage doctors (Section 3) and on how doctors manage being managed (Section 4) the two are of course closely related. Whether these forms of resistance by doctors are 'successful' in preserving the status quo of medical professionalism or whether the definition of what counts as medical professionalism shifts subtly over time to incorporate some 'managerial' values and practices is debated (Hoque and others, 2004; Waring, 2007; Kuhlmann and others, 2013).

How do doctor–managers bridge these divides?

Doctor–managers see themselves as doctors rather than managers

Many doctor managers see themselves first and foremost as doctors (Elina and others, 2006; Kippist and Fitzgerald, 2009; Cascon-Pereira and Hallier, 2012; Harvey and others, 2014; Vinot, 2014) although this is not universal at chief executive level (Ham and others, 2011). Many doctor managers do not regard themselves as managers (Ireri and others, 2011; Harvey and others, 2014); they prefer titles with 'clinical' in them which makes clear that they are also a clinician. They are not alone in being reluctant to embrace the term manager: many non-clinical managers also struggle to accept being identified as managers (Harvey and others, 2014).

Many doctor–managers take on management roles reluctantly (Hallier and Forbes, 2005; Kippist and Fitzgerald, 2009; Trebble and others, 2013; Harvey and others, 2014) and do them part-time for a limited period before reverting to a full-time clinical role (Greener and others, 2011). Many feel ambivalent or half-hearted towards their management roles (Hoque and others, 2004; Buchanan and others, 2013; Harvey and others, 2014) and see their primary loyalty as being towards their own professional group rather than to the organisation, particularly if the organisation is seen as in conflict with the medical profession. However, not all doctors are reluctant to embrace management roles and there may be cultural differences between specialties (Willcocks, 2004). It is possible that the types of research conducted and the level at which doctors' attitudes are assessed may obscure the individuals and contexts in which doctors have embraced management roles with enthusiasm (Hallier and Forbes, 2004; Harvey and others, 2014). Some doctors see management roles in terms of the advantages they might bring for the individual or for the professional group (e.g. as a way to advance the interests of their own specialty or to add an element of variety to their clinical role) (Hoque and others, 2004; Hallier and Forbes, 2005).

Maintaining clinical commitments and clinical credibility are seen as absolutely essential by both doctor–managers and doctors who are not managers (British Medical Association, 2012); failing to do so is seen as tantamount to having no influence at all over clinical colleagues (Fitzgerald and others, 2006; Dedman and others, 2011; Ireri and others, 2011; Dalmas, 2012; Dickinson and others, 2013b). However, many chief executives do relinquish a clinical role (Ham and others, 2011). Medical managers do not find it easy to carry out their dual roles: many struggle to balance clinical work and a managerial role and to fulfil their management duties within their allocated hours (British Medical Association, 2005; Greener and others, 2011).

Doctor–managers may occupy an uncomfortable middle ground

Doctor–managers rely heavily on their clinical credibility to influence clinical peers (Mo, 2008; Witman and others, 2010; Spehar and others, 2014) and draw on existing 'clan' networks for power and legitimacy (Vinot, 2014). Even retaining clinical commitments is necessary but not sufficient to ensure that doctor–managers will have any authority over medical colleagues. Doctor–managers usually have little or no positional power over medical peers who are themselves independent experts (Bohmer, 2012). Medical managers are widely regarded by other doctors with suspicion (Kippist and Fitzgerald, 2009; Greener and others, 2011; Ireri and others, 2011; Dickinson and others, 2013b; Trebble and others, 2013; Martin and others, 2015) and find that they have only limited ability to influence clinical peers (Braithwaite, 2004; British Medical Association, 2005; Fitzgerald and others, 2006; British Medical Association, 2012; Dickinson and others, 2013b; Harvey and others, 2014). They report struggling to deal with 'problem' doctors and having to use a range of strategies to deal with these types of management issues with medical colleagues (Ireri and others, 2011; Trebble and others, 2013). However, doctor–managers may struggle less with managing performance issues with medical peers than do managers responsible for managing diverse professional groups (Watson and others, 2012).

Thus, medical managers occupy an uncomfortable middle ground between management and medicine (Hallier and Forbes, 2005); they face a threat to their own identity as clinicians and risk jeopardising their own membership of the medical group (Harvey and others, 2014). Clinical peers may look to the doctor–manager to represent them and their interests (Thorne, 2002; Braithwaite, 2004) and may see perceived failure to do so as evidence of disloyalty to the profession. Many medical managers (particularly the 'middle management' layer of clinical directors) feel both excluded from management decision-making processes (Forbes and Hallier, 2006; Guven-Uslu, 2006) and somewhat separate from their clinical colleagues who may regard them as having 'gone over to the dark side' (Fitzgerald and others, 2006; Spurgeon and others, 2011). Strategies that clinical directors may adopt to try to increase their influence with colleagues include bolstering their own clinical commitment or presenting management initiatives using a 'systems' view rather than one that appears to be challenging the autonomy of individual clinicians (Hallier and Forbes, 2005).

Some medical managers find that managers fail to acknowledge the ongoing demands of the clinical role (Hallier and Forbes, 2005) and that they have limited access to management training and development (Fitzgerald and others, 2006; Bohmer, 2012), although this situation may be changing over time, with more trusts providing training programmes for medical leaders (Dickinson and others, 2013a). Where their experience conflicts with doctor–managers' expectations of what the role would provide and what their relationship with managers would be, doctor–managers may respond in different ways depending on whether they had initially embraced the role with enthusiasm or reluctance: the 'investors' or the 'reluctants' (Hallier and Forbes, 2005). Where the clinical director role feels particularly conflictual to doctors, they may adopt strategies that involve serving out their time with minimal engagement with their managerial duties while avoiding overt opposition, or directing their opposition at hospital management figures while continuing to serve the operational needs of the organisation (Hallier and Forbes, 2005).

Professional-management hybrids

The existence of professional-management 'hybrids' is the subject of much debate. Some authors suggest that such hybrids do exist and that there are different types of doctor–managers. One categorisation of 'ideal types' (Byrkjeflot and Jespersen, 2014) differentiates between the clinical manager (who mediates between traditional medical self-governance and general management logic), the commercialised manager (who combines medical self-governance with the enterprise logic of market arrangements) and the neo-bureaucratic manager (who combines medical self-governance with a bureaucratic system of regulations and procedures). Other authors (e.g. Jacobs, 2005; Martinussen and Magnussen, 2011) comment that, rather than hybrid professional-management forms (defined as all medical staff adopting management values and thus changing the nature of the profession), what can be seen is polarisation, as only a limited number of doctors adopt these values.

Doctor–managers are not a homogeneous group. Some authors (e.g. Fitzgerald and others, 2006) suggest that doctors are increasingly deriving status from their managerial work as well as from their clinical work. Indeed, a recent review points to the existence of 'managerial elites' (doctor–managers who are typically located within operational structures and continue to practise as doctors) as one of six categories of medical professional elites (Waring, 2014).

These experiences suggest that the expectations of policy-makers that involving more doctors in management will mean a greater degree of control over resources and medical practice and increased innovation and service improvement (Neogy and Kirkpatrick, 2009) may not be realised: doctors in management may well not take up an effective bridging role between medicine and management but instead may gravitate towards one end and adopt either a clinical or a managerial perspective or seek to preserve the status quo (Neogy and Kirkpatrick, 2009). It is also argued that some senior doctor–managers do 'colonise' and use managerial expertise and discourse deliberately and strategically to advance clinical interests (Thorne, 2002; Greener and others, 2011).

Does the policy context shape relationships between doctors and managers?

> " In less than a decade there have been at least four major reorganisations of health service structures, each of which, whatever the benefits, entailed disruption and distraction for NHS leaders and often bewilderment amongst the clinicians with whom they worked. The average time in post of a chief executive level leader in the NHS is measured in months, and a five-year tenure is exceptional, not least because the organisations they run may have been dismantled.
> *(Institute for Healthcare Improvement, 2008, p.20)*

The policy context has a very important influence on the relationships between doctors and managers: studies in a range of countries show that these relationships are shaped

in part by the policy context and history in that country (Kirkpatrick and others, 2009; Kirkpatrick and others, 2012; Bode and Dent, 2014) and that factors like the mode of governance of the hospital sector, the nature of organisational settlements with key professions, and the nature and process of public sector reforms are all relevant (Kirkpatrick and others, 2012).

We highlight here four features that research suggests have been particularly important in the UK in the past decade:

- the sustained and high-profile political and media critique of NHS management and NHS managers

- the organisational turbulence created by major reorganisations against a background of financial pressures

- the continuing policy trend towards reducing medical autonomy

- the intense and demanding nature of NHS management roles.

Sustained and high-profile critique of NHS management and NHS managers

There has been sustained and significant criticism in the press and by politicians of NHS managers and of management costs from at least the mid 1990s (Currie and Procter, 2002; Blackler, 2006). Recent years have seen sustained criticisms of NHS managers by politicians of all parties and these criticisms have been widely reflected in the media. Most recently the coalition government proposed a cut in the number of NHS management posts by at least 45% between 2010 and 2014 (Harvey and others, 2014). This contributed to the loss of experienced managers from the service even before the 'ill-advised' (Institute for Healthcare Improvement, 2008) and unprecedented major structural reform following the Health and Social Care Act 2012. Although The King's Fund Commission on Leadership and Management in the NHS (2011) strongly challenged the politicians' mantra that the NHS had too many managers, saying: "There is no persuasive evidence that the NHS is over-managed, and a good deal of evidence that it may be under-managed" (The King's Fund, 2011, p.viii), the position of NHS manager continues to be experienced by managers themselves as one that is stigmatised and vilified by politicians and by the press (Harvey and others, 2014).

Organisational turbulence and financial pressures

The history of the NHS is one of repeated structural reorganisations (Smith and others, 2001; Walshe, 2005, 2012) carried out against a background of considerable (and often severe) financial constraints. The financial pressures intensified under the coalition government since 2010, with analysts suggesting that the period after the financial year 2014/15 would require an unprecedented increase in NHS productivity or increased funding in real terms to avoid cuts in services or a fall in the quality of care (Roberts and others, 2012).

Writing in 2008, the Institute for Healthcare Improvement review of quality improvement in the NHS commented that policy churn, organisational instability and the consequent high turnover of managers made it harder for managers and doctors at local level to build up trusting, collaborative relationships (Institute for Healthcare Improvement, 2008). In similar vein, the Institute of Healthcare Management in 2015 observed that the endless cycle of NHS 'reform' made it more difficult to build and sustain good working relationships (Institute of Healthcare Management,

2015). Despite the strong messages urging organisational stability from international bodies that reported to the Darzi review in 2008, the period of coalition government after 2010 saw what has been described as the largest structural reorganisation of the NHS since its inception in 1948. Described by The King's Fund Commission on Leadership as "one of the most dramatic structural upheavals in its history" (The King's Fund, 2011, p.23) and by The King's Fund as a "distracting and damaging" top-down reorganisation with complex and confusing new systems of governance and accountability and an absence of clear system leadership (Ham and others, 2015), the Act led to high levels of management turnover and the loss of experienced managers (Ham, 2012; Ham and others, 2015). These reductions in management capacity and continuity occurred precisely at a time when both funding pressures and the structural changes imposed by the Act had magnified the scale of the management challenge.

Policy trend towards reducing medical autonomy

A further factor that affects relationships between doctors and managers is the policy trend over the past three decades towards increased managerial control over professional groups, fuelled partly by 'New Public Management' developments in the public sector (Waring, 2007; Currie and others, 2009; Kirkpatrick and others, 2009; Numerato and others, 2012; Kuhlmann and Von Knorring, 2014). 'New managerialism' and the associated emphasis by governments on centralisation and control may have exacerbated the 'them and us' dynamics of intergroup behaviour (Spurgeon and others, 2011): doctors perceive that the new managerialism challenges the traditional power of the medical profession and may respond by further boundary-drawing and non-communication in an attempt to preserve the status quo (Sarra, 2005).

While measures to create an 'internal market' in the 1990s contributed to strengthening the remit of managers in areas like finance and procurement (Kirkpatrick and others, 2009), the NHS has now also seen several decades of measures aimed at increasing the systematisation of health care (e.g. by increasing the use of guidelines) and at increasing multi-professional team-working (Salter, 2007; Kirkpatrick and others, 2009; Kirkpatrick and others, 2012; Jackson and others, 2013). These measures and others have often been seen by the medical profession as attempts to reduce their autonomy at a time when that autonomy is also under threat from a hostile media, from a public with greater access to information than in earlier decades (Gollop and others, 2004), and from politicians who scapegoat the medical profession when it is politically expedient to do so (Kirkpatrick and others, 2009; Checkland, 2014). This sense of 'threat' from successive government 'reforms' has contributed to a situation where doctors may be less likely to support service changes or to engage in management themselves (Salter, 2007; Kirkpatrick and others, 2009; Kirkpatrick and others, 2012).

Doctors often perceive managers as agents of government (Edwards, 2005; NHS Confederation, 2007; British Medical Association, 2012) and indeed, some managers see themselves as having this role (Hoque and others, 2004). Poor working relationships between doctors and managers may in part result from doctors' opposition to the provenance of the policies promoted (Taylor and Benton, 2008). Even when the proposals do not directly affect medical autonomy, many doctors object to what they perceive as a large number of national initiatives and targets imposed by government or by senior managers which are largely transient and driven by political whim with little opportunity for health care staff to influence them (Gollop and others,

2004). Many balk also at the implied suggestion behind changes in service provision that current systems or practices are inefficient or faulty (Gollop and others, 2004).

Conflict in relationships between doctors and managers has therefore been attributed in part to doctors' frustration with the direction of travel of national policies, with the frequent changes in policy and with a perceived lack of consultation or explanation for policy initiatives (NHS Confederation, 2007; British Medical Association, 2012). Thus in some cases opposition from doctors may not arise from hostility to managers per se but from opposition to the policies that managers are required to implement and to the manner of their implementation. Although both managers and doctors may perceive that the real power lies outside their organisation and that they are all subject to the power of policy-makers (Martin and others, 2015), managers may be seen as 'the messengers who are ripe for shooting'.

The term 'manager' may itself also be problematic because of its association in the minds of many doctors with unpopular market-based reforms in the public sector from the Thatcher era onwards; many health professionals may therefore resist both managers and a management role becoming part of their own work and seek to dismiss managers as 'mere administrators': "...the discursive history of the term manager in the NHS always has the denigrated shadow of the administrator behind it" (Learmonth, 2005, p.630).

The nature of NHS management roles

The fourth contextual factor that we would emphasise is the nature of NHS management roles. On top of the sustained political attention and critique that their role attracts, NHS managers work in highly challenging roles. These leave many of them with little spare capacity to nurture good working relationships with powerful groups of doctors as they struggle with the increasing demands placed on them and with the requirement to implement improvements in the quality and safety of services in the context of ongoing cuts in resources (Buchanan and others, 2013). It is unsurprising that doctor–manager relationships may suffer from the substantial demands that management and clinical roles both place on individuals.

Managers face a range of challenges in their daily working lives (Osbourne, 2011). They sometimes work in what might fairly be described as a bullying culture (NHS Confederation, 2007) and struggle with defining their identity and role and with the negative perception of managers held by the public and by many of their colleagues (Harvey and others, 2014). Further challenges include the limited preparation and training that many managers receive for their role and the relative lack of power, influence and authority. High workloads combine with the absence of robust evidence of 'what works' in many aspects of service delivery. NHS managers work under multiple, often conflicting or outdated organisational processes and structures and have to address the conflict between local challenges and the need to meet external reporting requirements.

NHS managers have been subject to government policy emphasising competition in recent decades and in particular in the period from 2002 (Mannion and others, 2009). This has been accompanied by a substantial shift in the predominant organisational culture at board level in NHS hospitals in England: from more supportive 'clan' cultures to more competitive 'rational' cultures (Mannion and others, 2009). This is likely to have affected how managers have defined and pursued objectives and

collaborated with managerial colleagues from other organisations and may well have affected their relationships with clinicians. Managers, unlike doctors, may be 'invisible' to patients and their relatives in normal circumstances and may therefore never receive the benefit of the positive feedback that many doctors value as a core element of their work (Thorne, 2002). Many managers experience the external performance management and regulation system as onerous and at times punitive (Thorlby and others, 2014) and this may hinder good working relationships between managers and doctors just as the earlier clinical governance reviews did (Benson and others, 2006).

It is NHS middle managers who may experience these pressures most acutely. Their roles have been described as 'extreme jobs': roles characterised by high pace and intensity, constant demands and long hours which put the post holder at risk of mistakes, burnout and fatigue (Buchanan and others, 2013). Middle managers often work in contexts in which they have high levels of responsibility but little power and significant constraints on their ability to act. Much of their work involves dealing with 'wicked problems' for which there are no straightforward solutions and on which perspectives will differ about the nature of the problem and the potential options (Buchanan and others, 2013). In contrast, much of traditional medical training may be based on a diagnostic or rational planning approach and so may not have equipped doctors to approach such issues effectively (Buchanan and others, 2013). Thus these differences in perspective can exacerbate conflict between doctors and managers.

In summary, the empirical studies show that both managers and doctors often feel beleaguered: criticised by politicians, struggling to perform the roles to which they aspire, and hindered by the requirement to implement frequent changes of policy which may not be workable and on which they do not feel consulted. It is unsurprising that relationships between the two groups are often challenging and at times confrontational.

3. The policy drive towards increasing clinical leadership

Around these troubled relationships documented above, the past decade has also seen an important policy shift affecting doctor–manager relationships in the NHS: the policy drive towards increasing clinical leadership (Storey and Holti, 2013). Policy-makers have become increasingly interested in the potential contribution of 'clinical engagement' to effective management of health services. In common with other countries like Australia, Canada and Denmark (Kirkpatrick and others, 2012; Sebastian and others, 2014), the UK has in the last five years seen a major policy emphasis on clinical leadership and medical engagement around patient safety and quality improvement (Storey and Holti, 2013). A wide range of initiatives has followed including the establishment of the NHS Leadership Academy (Martin and others, 2015). Clinical leadership was a strong theme in Darzi's vision for the NHS expressed in the 2008 publication *High Quality Care for All* (Spurgeon and others, 2011) while more recently the major project Enhancing Engagement in Medical Leadership aimed to encourage doctors to become more actively involved in leading NHS services and developed the Medical Leadership Competency Framework (British Medical Association, 2012; Clark, 2012b).

These developments can be interpreted as a major shift in emphasis towards clinical leadership as an alternative to health care management (Waring, 2014). In part this may have come about because the medical profession has consistently over the past few decades been able to retain considerable autonomy; policy-makers have therefore been searching for new and more effective ways to ensure broad alignment between the medical profession and wider system objectives around quality, safety and cost-effectiveness (Baker and Denis, 2011). The emphasis on clinical leadership can also be seen as the latest example of a long-running trend of political and media commentators calling for a reduction in the number of managers and for their power to be returned to the clinicians 'on the front line' (Walshe and Smith, 2011).

Whatever the drivers behind this policy, there is some evidence to suggest that having senior medical leadership in hospitals is beneficial in terms of financial and clinical quality (Veronesi and others, 2013, 2014). There is also a strong association between levels of medical engagement in NHS hospitals measured by the Medical Engagement Scale and financial and organisational performance as assessed by the Care Quality Commission (e.g. improved patient mortality rates, care quality etc) (Spurgeon and others, 2011; Clark, 2012b). However, the policy direction pushing towards leadership for all has been subject to some critique (e.g. Checkland, 2014).

It is argued that much of the commentary on leadership has used leadership as a rhetorical device, in a similar way to the earlier shift from 'administration' to management (Learmonth, 2005) and that insufficient attention has been paid to how leadership is defined, the characteristics that leaders have, the specific benefits that are assumed to follow from having major parts of the service managed by clinicians and

the need for leaders to have 'followers' (Storey and Holti, 2013; Checkland, 2014). A further critique argues that too much emphasis has been placed on a 'one size fits all' model of individual leadership development with little regard for the challenges of leading in variable local contexts and to the importance of relationships within and between organisations (Edmonstone, 2013; Storey and Holti, 2013; Martin and others, 2015). For example, one recent study found that some clinicians were rebuffed by senior managers when they attempted to get involved in issues outside their normal job role (Storey and Holti, 2013). Clinicians struggled to maintain legitimacy and autonomy through demonstrating accountability to multiple parties: to organisational managers, to the professional body and to patients and carers (Storey and Holti, 2013). Some clinical leaders "resigned themselves to a relatively restricted, fatalistic and even passive role in the face of brutal experience" (Storey and Holti, 2013, p.136).

Critics of the growing emphasis on 'distributed leadership' also argue that it simply represents the latest in a series of attempts over the years to persuade employees (in this case health professionals) to 'discipline' their own behaviour and thus reduce the need for external monitoring and management (Waring, 2014). The emphasis on clinical leadership as the solution to all of the challenges facing the NHS has also been seen as an attempt to place clinicians in the 'firing line' to be blamed for NHS failures (Checkland, 2014; Martin and others, 2015) and to deflect attention from other potential solutions to funding deficits or health inequalities that may be more politically contentious. Without sufficient training and support, doctors may be "merely very expensive and inexperienced managers" (Fitzgerald and others, 2006, p.18). The implication that 'management' has failed and that 'clinical leadership' is the solution seems unlikely to improve relationships between doctors and managers.

Although some evidence is emerging (e.g. Storey and Holti, 2013; Martin and others, 2015) it is too early to assess overall how successful this policy drive has been and what the positive and negative consequences may be. However, it needs to be considered against the background of the continuing challenges in attracting doctors in to senior management roles: high level engagement with management remains limited to a minority (Kirkpatrick and others, 2009) and only around 10–20% of consultants are involved in formal leadership roles (Dickinson and others, 2013b). A range of factors make board positions unattractive for doctors (e.g. the risk of clinical deskilling, the negative perceptions of managers by other doctors, the lack of financial incentives) (Loh, 2012; Janjua, 2014). It is unclear whether a majority of doctors will ever be willing to embrace clinical leadership roles at other levels.

Nevertheless, the response of the medical profession (at least at the level of its representative bodies) has largely been supportive: the profession has publicly acknowledged the need for the profession to engage with management (British Medical Association, 2012). For example, two reports published in the past decade by the Royal College of Physicians on the changing nature of medical professionalism (Royal College of Physicians, 2005; Levenson and others, 2008) both argue that leadership and followership skills need to be part of the core professional skill set and to be

included in medical training (Storey and Holti, 2013). The 2005 report emphasised the importance of the doctor–manager relationship:

> " Just as the patient doctor partnership is a pivotal therapeutic relationship in medicine, so the interaction between doctor and manager is central to the delivery of professional care.
> *(Royal College of Physicians, 2005, p.xii)*

This report set out the College's conclusions on doctors' responsibility to uphold professional values but also made clear that they saw it as the responsibility of managers "to help create an organisational infrastructure to support doctors in the exercise of their professional responsibilities" (Royal College of Physicians, 2005, p.xii). The intrinsic leadership role of doctors was also emphasised in a later joint report between medical and managerial bodies:

> " Doctors have a legal duty broader than any other health professional and therefore have an intrinsic leadership role within healthcare services. *(Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2009, p.6)*

A further sign of the recognition on the part of the medical profession that management is an important part of the role of doctors came with the establishment of the Faculty of Medical Leadership and Management in 2011: "to promote the advancement of medical leadership, management and quality improvement at all stages of the medical career for the benefit of patients". The Faculty runs the National Medical Director's Clinical Fellow Scheme which gives junior doctors the opportunity to apply for a one year secondment to develop skills in leadership, management and health policy (Rodrigues and Bladen, 2013). Moreover, recent GMC guidance (General Medical Council, 2012) addressed to all doctors emphasises that all doctors have leadership and management responsibilities, whether they are in formal management roles or not. It states that all doctors are required to engage with managers and other colleagues to maintain and improve the safety and quality of care, emphasising: "You should respect the leadership and management roles of other team members, including non-medical colleagues" (General Medical Council, 2012, p.8).

In summary, there has been a strong policy drive in the past five years or so towards increasing 'clinical leadership' and engaging doctors at all levels in some form of management role. At the level of their representative bodies, the medical profession has endorsed this shift, but it is too soon to assess the progress of its implementation and the impact of this change on the doctor–manager relationship.

4. Improving doctor–manager relationships

The literature over the past decade has suggested a range of approaches that may be useful in improving doctor–manager relationships (Spurgeon and others, 2011). These include paired learning and shadowing initiatives, enabling clinicians in leadership positions to work closely alongside managerial colleagues to solve common problems (e.g. in quality and safety) (Marshall, 2008), and providing working environments that encourage informal interactions (e.g. in shared common room facilities) (Institute of Healthcare Management, 2015). The Institute for Healthcare Improvement framework for engaging doctors in quality and safety (Reinertsen and others, 2007) provides key principles for developing multifaceted approaches (Clark, 2012a):

- discover common purpose: recognising the existing culture

- reframe values and beliefs

- segment the engagement plan

- use 'engaging' improvement methods

- show courage

- adopt an engaging style.

Many commentators suggest that early contact between managers and doctors in training can help to forge greater understanding: such initiatives can include early interdisciplinary education, buddy schemes to pair junior doctors and managers (Parker and others, 2014) and quality improvement forums in which junior doctors and managers can work collaboratively to address problems identified by junior doctors (Parker and others, 2014). Shared management training may be helpful providing that these courses are not rooted in uncritical, acontextual understandings of management or based on the blanket translation of generic management approaches from industry but instead are firmly rooted in the challenges of managing in a health care context, allow exploration of the different perspectives of managers and clinicians and allow them to work together on live issues affecting their organisation (Greener and others, 2011). Such joint training might usefully incorporate training to help individuals with managing uncertainty and with the challenges to self-identity arising from different professional roles (Baathe and Norback, 2013) and training about the impact of psychological processes at the organisational level (Garelick and Fagin, 2005).

Central to many of the approaches suggested are an emphasis on facilitated dialogue and conflict resolution (Kaissi, 2014) and on seeking to acknowledge and foster shared values, building on the existing interests and motivations that doctors and managers have in common (Plochg and Klazinga, 2005; Fitzgerald and others, 2006; Taylor and Benton, 2008). It is suggested that opportunities for dialogue outside the constraints of formal work settings may be useful to help develop mutual trust and 'sense-making' and to reduce the perception of 'parallel universes' (Sarra, 2005; MacLeod, 2012).

Several authors suggest that it may be helpful to focus on developing a collaborative culture around collective organisational issues rather than attempting to meld two disparate cultures (MacLeod, 2012; Kaissi, 2014): recognising and accepting the many professional differences that exist between managers and doctors and drawing on the strengths of those cultures to solve organisational problems. For example, one of the strengths of medical professionalism, the support for innovations in treatment, can be harnessed while recognising and seeking to address the weaknesses of professionalism (e.g. the tendency towards turf battles). Building on the existing regulatory practices of the medical profession and working with the professional tendency towards adaptive regulation are likely to be more successful than imposing new systems to regulate or manage the profession (Waring, 2007).

Such approaches involve recognising that individuals and groups have significant investments in constructing and reinforcing their social identities and will not easily relinquish them. It may therefore be most fruitful not to ignore or attempt to reduce these differences but instead to seek opportunities to promote alignment alongside these distinct identities (Kreindler and others, 2014). Longitudinal research in one health care setting in Canada (Reay and Hinings, 2009) suggests that there is a variety of ways that multiple 'competing logics' (e.g. the 'incumbent' logic of medical professionalism and the 'challenger' logic of business-like health care) can co-exist. They suggest that there are mechanisms of collaboration that can support the co-existence of competing logics rather than competition between them or the development of hybrids. One helpful strategy may be to try to develop a unifying language or narrative around shared objectives: for example, by using the term 'safer care' rather than 'clinical governance' (Atkinson and others, 2011).

A key problem for managers is that they find that their influence is limited by the perceptions of other staff groups (upwards, downwards and laterally) (Harvey and others, 2014). This means that there is a need to improve the perceptions that groups have of the work that other staff groups do. Another important strand of improving doctor–manager relationships will be to improve relationships between medical managers and their clinical colleagues: there are continuing challenges in attracting doctors into senior management roles and one of the longstanding key factors that makes management roles unattractive to many doctors and limits their effectiveness within these posts (British Medical Association, 2012) is the perceived or actual impact on their relationships with clinical colleagues (Fitzgerald and others, 2006). It is argued that the roles taken by doctors as clinical directors and medical directors need to be accepted and valued as a normal part of a medical career and that this requires clear career pathways, appropriate pay and reward systems and the provision of re-training (as required) for those who subsequently return to clinical work (Spurgeon and others, 2011).

Improving these relationships within the medical profession may also indirectly help to improve the relationship between doctors and managers by shifting the belief that management roles are low status posts occupied largely by non-clinicians. Such approaches may be more likely to be fruitful than those that seek to improve the doctor–manager relationship by working through third parties, for example using nurses as the 'bridge' between medical and managerial perspectives (Kaissi, 2008) or relying on empowered patients and their relatives to challenge dysfunctional doctor–manager relationships (Institute for Healthcare Improvement, 2008) (of which they may be unaware).

5. Concluding remarks

Using the framework of the six key themes that emerged from our reading of the literature, we have explored what a range of empirical studies have shown about perceptions of doctor–manager relationships in secondary care in the NHS in the past decade or so.

The empirical studies in the UK at medical director and clinical director level published since 2002 bear out the observations of the 2013 Francis report and the 2015 Institute of Healthcare Management survey that relationships between doctors and managers continue to be challenging. Whether these tensions constitute a 'gulf' between the two groups (Francis, 2013) is debatable, but significant challenges are certainly widespread. A further difficulty lies in the fact that many of these practices, behaviours and responses have a long organisational history and may be operating at levels below the conscious awareness of individuals: for example, doctors and managers may collude in rituals around appraisal and be unaware that this is happening (McGivern and Ferlie, 2007). It is, however, important to note that there is no uniform pattern of doctor–manager relationships and that the 'group' level of much of the research may be obscuring differences within individual hospitals and departments (Hallier and Forbes, 2005). International studies suggest that doctor–manager relationships are characterised by diversity, variety and heterogeneity (Kuhlmann and others, 2013). As one US report observed, "there is no such thing as 'physician engagement in general'": it is finely grained and nuanced, requiring specific changes within individual clinicians (Reinertsen and others, 2007, p.13). An earlier observation made by UK researchers in 1999 is also very likely to be relevant still:

> **While at a collective level it is useful to continue to think of doctors and managers as adversarial superpowers, the micro-level reality is more complex and reveals some fascinating compromises, alliances and innovations.**
> *(McKee and others, 1999, p.90)*

Indeed a more recent study of seven trusts with high levels of medical engagement (Atkinson and others, 2011) found that these organisations had histories of variable doctor–manager relationships. Some relationships had worked well while others had been dysfunctional. This suggests that there may be grounds for some optimism: good doctor–manager relationships in the past are not a necessary precursor to developing high levels of medical engagement in the present.

There appears to have been no comparable research study at scale since the national NHS survey of perceptions of the doctor–manager relationship was carried out in 2002 (Davies and others, 2003a, b). Given the significant changes in the policy landscape since that survey was undertaken (including the Darzi review in 2008, the publication of the two Francis reports in 2010 and 2013 and the changes introduced by the coalition government including the Health and Social Care Act in 2012), we believe

that it is helpful to revisit the issues explored in the earlier survey and to consider the impact of the latest policy developments on the perceptions of doctors and managers. This is explored in *Managing doctors, doctors managing.*

References

Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2009) *Medical Leadership Competency Framework: Enhancing engagement in medical leadership.* Second Edition, May 2009. NHS Institute for Innovation and Improvement, London.

Ackroyd S, Kirkpatrick I and Walker RM (2007) Public management reform in the UK and its consequences for professional organization: a comparative analysis. *Public Administration* 85: 9–26.

Arndt M and Bigelow B (2007) Hospital administration in the early 1900s: visions for the future and the reality of daily practice. *Journal of Healthcare Management* 52: 34-47.

Atkinson S, Spurgeon P, Clark J and Armit K (2011) *What can we learn from trusts with high levels of medical engagement?* NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, Warwick.

Baathe F and Norback LE (2013) Engaging physicians in organisational improvement work. *Journal of Health Organization and Management* 27: 479-497.

Baker GR and Denis J-L (2011) Medical leadership in health care systems: from professional authority to organizational leadership. *Public Money and Management*: 355–362.

Benson LA, Boyd A and Walshe K (2006) Learning from regulatory interventions in healthcare: The Commission for Health Improvement and its clinical governance review process. *Clinical Governance: An International Journal* 11: 213–224.

Berwick D (1996) A primer on leading the improvement of systems. *British Medical Journal* 312: 619-622.

Blackler F (2006) Chief Executives and the Modernization of the English National Health Service. *Leadership* 2: 5–30.

Bode I and Dent M (2014) Converging hybrid worlds? Medicine and hospital management in Europe. *International Journal of Public Sector Management* 27.

Bohmer R (2012) *The instrumental value of medical leadership.* The King's Fund, London.

Braithwaite J (2004) An empirically-based model for clinician-managers' behavioural routines. *Journal of Health Organization and Management* 18: 240–261.

British Medical Association (2005) Survey of workload and remuneration of medical managers. British Medical Association, London.

British Medical Association (2012) *Doctors' perspectives on clinical leadership.* Health Policy and Economic Research Unit, British Medical Association.

Brown P, Alaszewski A, Pilgrim D and Calnan MW (2011) The quality of interaction between managers and clinicians: a question of trust. *Public Money and Management* 31: 43-50.

Buchanan DA, Denyer D, Jaina J, Kelliher C, Moore C and Parry E (2013) How do they manage? A qualitative study of the realities of middle and front-line management work in health care. *Health Serv Deliv Res* 1.

Byrkjeflot H and Jespersen PK (2014) Three conceptualizations of hybrid management in hospitals. *International Journal of Public Sector Management* 27: 441-458.

Cascon-Pereira R and Hallier J (2012) Getting that certain feeling: the role of emotions in the meaning, construction and enactment of doctor managers' identities. *British Journal of Management* 23: 130–144.

Checkland C (2014) Leadership in the NHS: does the Emperor have any clothes? *Journal of Health Services Research and Policy* 19: 253–256.

Clark J (2012a) *Medical engagement: Too important to be left to chance.* The King's Fund, London.

Clark J (2012b) Medical leadership and engagement: no longer an optional extra. *Journal of Health Organization and Management* 26: 437-443.

Clark J and Nath V (2014) *Medical engagement: a journey, not an event.* The King's Fund, London.

Crilly T and Le Grand J (2004) The motivation and behaviour of hospital trusts. *Social Science and Medicine* 58: 1809–1823.

Currie G, Humpreys M, Waring J and Rowley E (2009) Narratives of professional regulation and patient safety: The case of medical devices in

anaesthetics. *Health, Risk and Society* 11: 117–135.

Currie G and Procter S (2002) Impact of MIS/IT upon middle managers: some evidence from the NHS. *New Technology, Work and Employment* 17: 102–118.

Currie G and Procter S (2005) The antecedents of middle managers' strategic contribution: the case of a professional bureaucracy. *Journal of Management Studies* 42: 1325–1356.

Currie G and Suhomlinova O (2006) The impact of institutional forces upon knowledge sharing in the UK NHS: the triumph of professional power and the inconsistency of policy. *Public Administration* 84: 1–30.

Dalmas M (2012) Involving clinicians in hospital management roles: towards a functional integrative approach *The International Journal of Clinical Leadership* 17: 139–145.

Davies HTO, Hodges C-L and Rundall TG (2003a) Consensus and contention: doctors' and managers' perceptions of the doctor–manager relationship. *British Journal of Healthcare Management* 9: 202–208.

Davies HTO, Hodges C-L and Rundall TG (2003b) Views of doctors and managers on the doctor–manager relationship in the NHS. *BMJ* 326: 626-628.

Dedman GL, Nowak MJ and Klass DJ (2011) The dimensions of efficiency and effectiveness of clinical directors: perceptions of clinical directors and senior management in Western Australian public teaching hospitals. *The International Journal of Clinical Leadership* 17: 61-71.

Degeling P, Kennedy J and Hill M (2001) Mediating the cultural boundaries between medicine, nursing and management - the central challenge in hospital reform. *Health Services Management Research* 14: 36-48.

Degeling P and Maxwell S (2004) The negotiated order of health care. *Journal of Health Services Research and Policy* 9: 119–121.

Degeling P, Maxwell S, Kennedy J and Coyle B (2003) Medicine, management and modernisation: a "danse macabre"? *British Medical Journal* 326: 649-652.

Degeling P, Zhang K, Coyle B, Xu L, Meng Q, Qu J and Hill M (2006) Clinicians and the governance of hospitals: A cross-cultural perspective on relations between professions and management. *Social Science and Medicine* 63: 757-775.

Dickinson H, Ham C, Snelling I and Spurgeon P (2013a) *Are we there yet? Models of medical leadership and their effectiveness: An exploratory study.* Final report. NIHR Service Delivery and Organisation programme.

Dickinson H, Ham C, Snelling I and Spurgeon P (2013b) Medical leadership arrangements in English healthcare organisations: Findings from a national survey and case studies of NHS trusts. *Health Services Management Research* 26: 119–125.

Dwyer AJ (2010) Medical managers in contemporary healthcare organisations: a consideration of the literature. *Australian Health Review* 34: 514-522.

Edmonstone J (2013) What is wrong with leadership development? *British Journal of Healthcare Management* 19: 531-538.

Edwards N (2005) Doctors and managers: building a new relationship. *Clinical Medicine* 5: 577-579.

Eeckloo K, Delesie L and Vieugels A (2007) Where is the pilot? The changing shapes of governance in the European hospital sector. *Journal of the Royal Society for the Promotion of Health* 127: 78-86.

Elina V, Juhani L, Tiina T-J, Kari M, Irma V, Mauri I, Harri H, Esko K, Hannu H, Santero K and Jukka V (2006) Doctor–managers as decision makers in hospitals and health centres. *Journal of Health Organization and Management* 20: 85-94.

Fitzgerald L, Lilley C, Ferlie E, Addicott R, McGivern G and Buchanan D (2006) *Managing change and role enactment in the professionalised organisation.* NCCSDO, London.

Forbes T and Hallier J (2006) Social identity and self-enactment strategies: adapting to change in professional-manager relationships in the NHS. *Journal of Nursing Management* 14: 34-42.

Francis R (2010) *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005-March 2009.* The Stationery Office, London.

Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. The Stationery Office, London.

Garelick A and Fagin L (2005) The doctor–manager relationship. *Advances in Psychiatric Treatment* 11: 241–252.

General Medical Council (2012) *Leadership and management for all doctors.* General Medical Council, London.

Giordano R (2010) *Leadership needs of medical directors and clinical directors.* King's Fund, London.

Gollop R, Whitby E, Buchanan D and Ketley D (2004) Influencing sceptical staff to become supporters of service improvement: a qualitative study of doctors' and managers' views. *Quality and Safety in Health Care* 13: 108–114.

Greener I (2005) Health management as strategic behaviour: Managing medics and performance in the NHS. *Public Management Review* 7: 95–110.

Greener I (2007) The politics of gender in the NHS: impression management and getting things done. *Gender, Work and Organization* 14: 281–299.

Greener I, Harrington B, Hunter D, Mannion R and Powell M (2011) *A realistic review of clinico-managerial relationships in the NHS: 1991–2010.* Final report. NIHR Service Delivery and Organisation Programme. NIHR, Southampton.

Guven-Uslu P (2006) Use of performance metrics in clinical and managerial networks. *Public Money and Management* April 2006: 95–100.

Hallier J and Forbes T (2004) In search of theory development in grounded investigations: Doctors' experiences of managing as an example of fitted and prospective theorizing. *Journal of Management Studies* 41: 1379–1410.

Hallier J and Forbes T (2005) The role of social identity in doctors' experience of clinical managing. *Employee Relations* 27: 47-70.

Ham C (2012) The management of the NHS in England. *British Medical Journal* 344: e928. Ham C, Baird B, Gregory S, Jabbal J and Alderwick H (2015) The NHS under the coalition government. Part one: NHS reform. The King's Fund, London.

Ham C, Clark J, Spurgeon P, Dickinson H and Armit K (2011) Doctors who become chief executives in the NHS: from keen amateurs to skilled professionals. *Journal of the Royal Society of Medicine* 104: 113–119.

Ham C and Dickinson H (2008) *Engaging doctors in leadership: What can we learn from international experience and research evidence?* NHS Institute for Innovation and Improvement, London.

Harrison S (2009) Co-optation, commodification and the medical model: governing UK medicine since 1991. *Public Administration* 87: 184–197.

Harrison S and Lim JNW (2003) The frontier of control: doctors and managers in the NHS 1966 to 1997. *Clinical Governance: An International Journal* 8: 13–18.

Harvey J, Annandale E, Loan-Clarke J, Suhomlinova O and Teasdale N (2014) Mobilising identities: the shape and reality of middle and junior managers' working lives - a qualitative study. *Health Services and Delivery Research* 2.

Hoque K, Davis S and Humphreys M (2004) Freedom to do what you are told: senior management team autonomy in an NHS acute trust. *Public Administration* 82: 355–375.

Institute for Healthcare Improvement (2008) *Achieving the Vision of Excellence in Quality: recommendations for the English NHS System of Quality Improvement.* Institute for Healthcare Improvement, Cambridge, MA.

Institute of Healthcare Management (2015) *Creating stronger relationships between managers and clinicians.* Institute of Healthcare Management, London.

Ireri S, Walshe K, Benson LA and Mwanthi MA (2011) A qualitative and quantitative study of medical leadership and management: experiences, competencies and development needs of doctor managers in the United Kingdom. *Journal of Management and Marketing in Healthcare* 4: 16–29.

Jackson WJ, Paterson AS, Pong CKM and Scarparo S (2013) Doctors under the microscope: the birth of medical audit. *Accounting History Review* 23: 23-47.

Jacobs K (2005) Hybridisation or polarisation: doctors and accounting in the UK, Germany and Italy. *Financial Accountability and Management* 21: 135–161.

Janjua A (2014) *Leadership vacancies in the NHS: what can be done about them?* The King's Fund, London.

Joint Commission International (2008) *Quality Oversight in England - Findings, Observations, and Recommendations for a New Model.* Joint Commission International, Oak Brook, Illinois.

Kaissi A (2008) The role of nursing in bridging the

gap between managers and physicians in hospitals. *The Health Care Manager* 27: 113–117.

Kaissi A (2014) Enhancing physician engagement: an international perspective. *International Journal of Health Services* 44: 567-592.

Kippist L and Fitzgerald A (2009) Organisational professional conflict and hybrid clinician managers. *Journal of Health Organization and Management* 23: 642-655.

Kippist L and Fitzgerald A (2012) Breaking down professional boundaries: how can doctors and managers work together to better manage health care organisations? *Employment Relations Record* 12: 34-47.

Kirkpatrick I, Bullinger B, Dent M and Lega F (2012) The development of medical-manager roles in European hospital systems: a framework for comparison. *International Journal of Clinical Practice* 66: 121–124.

Kirkpatrick I, Jespersen PK, Dent M and Neogy I (2009) Medicine and management in a comparative perspective: the case of Denmark and England. *Sociology of Health and Illness* 31: 642-658.

Kirkpatrick I, Shelly M, Dent M and Neogy I (2008) Towards a productive relationship between medicine and management: reporting from a national inquiry. *The International Journal of Clinical Leadership* 16: 27–35.

Klaber B, Lee J, Abraham R, Smith L and Lemer C (2012) *Paired learning: A peer-learning leadership development initiative for managers and clinicians in the NHS.* Imperial College Healthcare NHS Trust and NHS London.

Klopper-Kes AHJ, Meerdink N, van Harten WH and Wilderom C (2009) Stereotypical images between physicians and managers in hospitals. *Journal of Health Organization and Management* 23: 216–224.

Klopper-Kes AHJ, Siesling S, Meerdink N, Wilderom CPM and Van Harten WH (2010) Quantifying culture gaps between physicians and managers in Dutch hospitals: a survey. *BMC Health Services Research* 10.

Kreindler SA, Larson BK, Wu FM, Gbemudu JN, Carluzzo KL, Struthers A, Van Citters AD, Shortell SM, Nelson EC and Fisher ES (2014) The rules of engagement: physician engagement strategies in intergroup contexts. *Journal of Health Organization and Management* 28: 41-61.

Kuhlmann E, Burau V, Correia T, Lewandowski R, Lionis C and Noordegraaf M (2013) "A manager in the minds of doctors": a comparison of new modes of control in European hospitals. *BMC Health Services Research* 13.

Kuhlmann E and Von Knorring M (2014) Management and medicine: why we need a new approach to the relationship. *Journal of Health Services Research and Policy* 19: 189–191.

Learmonth M (2005) Doing things with words: the case of 'management' and 'administration'. *Public Administration* 83: 617-637.

Levenson R, Dewar S and Shepherd S (2008) *Understanding doctors, harnessing professionalism.* The King's Fund/Royal College of Physicians, London.

Lipworth W, Little M, Markham P, Gordon J and Kerridge I (2013) Doctors on status and respect: a qualitative study. *Bioethical Inquiry* 10: 205–217.

Loh E (2012) How and why doctors transition from clinical practice to senior hospital management: a case research study from Victoria, Australia. *The International Journal of Clinical Leadership* 17: 235–244.

Macfarlane F, Exworthy M, Wilmott M and Greenhalgh T (2011) Plus ca change, plus c'est la meme chose: senior NHS managers' narratives of restructuring. *Sociology of Health and Illness* 33: 914-929.

MacIntosh R, Beech N and Martin G (2012) Dialogues and dialectics: Limits to clinician-manager interaction in healthcare organizations. *Social Science and Medicine* 74: 332–339.

MacLeod L (2012) The physician leader's role in bridging the culture gap. *Physician Executive* 38: 12–15.

Mannion R, Harrison S, Jacobs R, Konteh F, Walshe K and Davies HTO (2009) From cultural cohesion to rules and competition: the trajectory of senior management culture in English NHS hospitals, 2001–2008. *Journal of the Royal Society of Medicine* 102: 332–336.

Marshall M (2008) Doctors, managers and the battle for quality. *Journal of the Royal Society of Medicine* 101: 330–331.

Martin G, Beech N, MacIntosh R and Bushfield S (2015) Potential challenges facing distributed leadership in health care: evidence from the UK National Health Service. *Sociology of Health and Illness* 37: 14–29.

Martinussen PE and Magnussen J (2011) Resisting market-inspired reform in healthcare: The role of professional subcultures in medicine. *Social Science and Medicine* 73: 193–200.

McGivern G and Ferlie E (2007) Playing tick-box games: Interrelating defences in professional appraisal. *Human Relations* 60: 1361–1385.

McGlynn EA, Shekelle P and Hussey P (2008) *Developing, disseminating and assessing standards in the National Health Service.* RAND Health, Cambridge, MA.

McKee L, Marnoch G and Dinnie N (1999) Medical managers: puppetmasters or puppets? Sources of power and influence in clinical directorates. In *Organisational behaviour in health care: the research agenda* (Mark AL and Dopson S eds.). Macmillan, Basingstoke, pp. 89–116.

Mo TO (2008) Doctors as managers: moving towards general management. *Journal of Health Organization and Management* 22: 400-415.

Moore C (2011) *Knowing me, knowing you: interpersonal relationships between managers and hospital consultants.* Cranfield Healthcare Management Group Research Briefing 11. Cranfield University School of Management

Moore C and Buchanan DA (2013) Sweat the small stuff: A case study of small-scale change processes and consequences in acute care. *Health Services Management Research* 26: 9–17.

Morgan PI and Ogbonna E (2008) Subcultural dynamics in transformation: a multi-perspective study of healthcare professionals. *Human Relations* 61: 39-65.

Mueller F, Harvey C and Howorth C (2003) The contestation of archetypes: negotiating scripts in a UK hospital trust board. *Journal of Management Studies* 40: 1971–1995.

Neale G, Vincent C and Darzi A (2007) The problem of engaging hospital doctors in promoting safety and quality in clinical care. *Journal of the Royal Society for the Promotion of Health* 127: 87-94.

Neogy I and Kirkpatrick I (2009) *Medicine in Management: Lessons across Europe.* Centre for Innovation in Health Management, University of Leeds, Leeds.

NHS Confederation (2007) *The challenges of leadership in the NHS.* NHS Confederation, London.

Nicol ED, Mohanna K and Cowpe J (2014)

Perspectives on clinical leadership: a qualitative study exploring the views of senior healthcare leaders in the UK. *Journal of the Royal Society of Medicine* 107: 277–286.

Numerato D, Salvatore D and Fattore G (2012) The impact of management on medical professionalism : a review. *Sociology of Health and Illness* 34: 626-644.

Osbourne JA (2010) *What motivates NHS managers?* Cranfield Healthcare Management Group Research Briefing 3. Cranfield University School of Management.

Osbourne JA (2011) *Challenges facing healthcare managers: what past research reveals.* Cranfield Healthcare Management Group Research Briefing 6. Cranfield University School of Management.

Parker S, Martin F, Lipton J, Lock B, Gately A, Sloman D and Garside P (2014) The lessons learned from two quality improvement forums. *British Journal of Healthcare Management* 20: 124–131.

Plochg T and Klazinga NS (2005) Talking towards excellence: a theoretical underpinning of the dialogue between doctors and managers. *Clinical Governance: An International Journal* 10: 41-48.

Reasbeck PG (2008) Relationships between doctors and managers in an acute NHS trust. *The International Journal of Clinical Leadership* 16: 79-88.

Reay T and Hinings CR (2009) Managing the rivalry of competing institutional logics. *Organization Studies* 30: 629-652.

Reinertsen JL, Gosfield AG, Rupp W and Whittingtton JW (2007) *Engaging Physicians in a Shared Quality Agenda.* IHI Innovation Series White Paper. Institute for Healthcare Improvement, Cambridge, Massachusetts.

Roberts A, Marshall L and Charlesworth A (2012) *A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22.* Nuffield Trust, London.

Rodrigues IA and Bladen JC (2013) Clinical management: are times about to change? *British Journal of Healthcare Management* 19: 133–135.

Royal College of Physicians (2005) *Doctors in society: Medical professionalism in a changing world.* Royal College of Physicians, London.

Saario S (2012) Managerial reforms and specialised psychiatric care: a study of resistive practices performed by mental health practitioners. *Sociology of Health and Illness* 34: 896-910.

Salter B (2007) Governing UK medical performance: A struggle for policy dominance. *Health Policy* 82: 263–275.

Sarra N (2005) "When we cannot act as we wish, we must act as we can": Invited commentary on The doctor–manager relationship. *Advances in Psychiatric Treatment* 11: 250–252.

Scarparo S (2006) The integration of clinical and costing information: a comparative study between Scotland and Sweden. *Financial Accountability and Management* 22: 133–155.

Sebastian A, Fulop L, Dadich A, Fitzgerald A, Kippist L and Smyth A (2014) Health LEADS Australia and implications for medical leadership. *Leadership in Health Services* 27: 355–370.

Smith J, Walshe K and Hunter DJ (2001) The 'redisorganisation' of the NHS. *British Medical Journal* 323: 1262–1263.

Snell AJ, Briscoe D and Dickson G (2011) From the inside out: the engagement of physicians as leaders in health care settings. *Qualitative Health Research* 21: 952-967.

Snow SJ (2013) 'I've never found doctors to be a difficult bunch': doctors, managers andNHS reorganisations in Manchester and Salford, 1948–2007. *Med. Hist.* 57: 65-86.

Som CV (2005) Nothing seems to have changed, nothing seems to be changing and perhaps nothing will change in the NHS: doctors' response to clinical governance. *International Journal of Public Sector Management* 18: 463-477.

Spehar I, Frich JC and Kjekshus LE (2014) Clinicians in management: a qualitative study of managers' use of influence strategies in hospitals. *BMC Health Services Research* 14: 251.

Spurgeon P, Barwell F and Mazelan P (2008) Developing a medical engagement scale (MES). *The International Journal of Clinical Leadership* 16: 213–223.

Spurgeon P, Clark J and Ham C (2011) *Medical leadership: From the dark side to centre stage*. Radcliffe Publishing, London.

Storey J and Holti R (2009) Sense-making by clinical and non-clinical executive directors within new governance arrangements. *Journal of Health Organization and Management* 23: 149–169.

Storey J and Holti R (2013) *Possibilities and pitfalls for clinical leadership in improving service quality, innovation and productivity, Final report.* NIHR Service Delivery and Organisation programme, Southampton.

Taylor H and Benton S (2008) The doctor–manager relationship: a behavioural barrier to effective health care? *Medical and Care Compunetics* 5: 225–240.

The King's Fund (2011) *The future of leadership and management in the NHS: No more heroes.* Report from The King's Fund Commission on Leadership and Management in the NHS. The King's Fund, London.

The King's Fund (2014) *Culture and leadership in the NHS: The King's Fund 2014 survey.* The King's Fund, London.

Thorlby R, Smith J, Williams S and Dayan M (2014) *The Francis Report: one year on.* Nuffield Trust, London.

Thorne ML (2002) Colonizing the new world of NHS management: the shifting power of professionals. *Health Services Management Research* 15: 14–26.

Trebble TM, Cruickshank L, Hockey PM, Heyworth N, Powell T and Clarke N (2013) Individual performance review in hospital practice: the development of a framework and evaluation of doctors' attitudes to its value and implementation. *BMJ Quality and Safety* 22: 948-955.

Turner S, Ramsay A and Fulop N (2013) The role of professional communities in governing patient safety. *Journal of Health Organization and Management* 27: 527-543.

van Wijngaarden JDH, Botje D, Ilinca S, van der Waa N, Velosa Mendes R, Hamer S and Plochg T (2012) How doctor involvement in management affects innovation. *International Journal of Healthcare Management* 5: 203–207.

Veronesi G, Kirkpatrick I and Vallascas F (2013) Clinicians on the board: what difference does it make? *Social Science and Medicine* 77: 147–155.

Veronesi G, Kirkpatrick I and Vallascas F (2014) Does clinical management improve efficiency? Evidence from the English National Health Service. *Public Money and Management*: 35-42.

Vinot D (2014) Transforming hospital management a la francaise. *International Journal of Public Sector Management* 27: 406-416.

Vlastarakos PV and Nikolopoulos TP (2007) The interdisciplinary model of hospital administration: do health professionals and managers look at it in the same way? *European Journal of Public Health* 18: 71-76.

von Knorring M, de Rijk A and Alexanderson K (2010) Managers' perceptions of the manager role in relation to physicians: a qualitative interview study of

the top managers in Swedish healthcare. *BMC Health Services Research* 10.

Waldman JD, Smith HL and Hood JN (2006) Healthcare CEOs and physicians: reaching common ground. *Journal of Healthcare Management* 51: 171–183.

Walshe K (2005) Health care under New Labour: rebuilding or dismantling the NHS? *British Journal of Health Care Management* 11: 73-76.

Walshe K (2012) Lansley's legacy. *British Medical Journal* 345: e6109.

Walshe K and Smith L (2011) The NHS management workforce. The King's Fund, London. Waring J (2007) Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. *Sociology of Health and Illness* 29: 163–179.

Waring J (2014) Restratification, hybridity and professional elites: questions of power, identity and relational contingency at the points of professional-organisational intersection. *Sociology Compass* 8: 688-704.

Waring J and Currie G (2009) Managing expert knowledge: organizational challenges and managerial

futures for the UK medical profession. *Organization Studies* 30: 755-778.

Waring JJ (2005) Beyond blame: cultural barriers to medical incident reporting. *Social Science and Medicine* 60: 1927–1935.

Watson V, Sussex J, Ryan M and Tetteh E (2012) Managing poorly performing clinicians: Health care providers' willingness to pay for independent help. *Health Policy* 104: 260–271.

Wiig S, Aase K, von Plessen C, Burnett S, Nunes F, Weggelaar A-M, Anderson-Gare B, Calltorp J, Fulop N (2014) Talking about quality: exploring how 'quality' is conceptualized in European hospitals and healthcare systems. *BMC Health Services Research* 14: 478.

Willcocks SG (2004) Clinician managers and cultural context: comparisons between secondary and primary care. *Health Services Management Research* 17: 36-46.

Witman Y, Smid GAC, Meurs PL and Willems DL (2010) Doctor in the lead: balancing between two worlds. *Organization* 18: 477-495.

About the authors

Alison Powell is a Senior Research Fellow at the University of St Andrews. Her research interests lie in knowledge mobilisation, organisational change and quality improvement in health services. She is particularly interested in the impact of national and local policies on the delivery of care, the role played by professional identities and boundaries, and initiatives to increase the effective use of research. Prior to entering research 16 years ago, Alison held a variety of posts in and around the NHS including working in operational NHS management, working as a midwife, and supporting national policy negotiations on doctors' terms and conditions of service at the British Medical Association.

Huw Davies is a Professor of Health Care Policy and Management at the University of St Andrews. Huw's research interests are in public service delivery, especially in health care, encompassing evidence-based policy and practice, performance measurement and management, accountability, governance and trust. He also has a particular interest in the role of organisational culture and organisational learning in the delivery of high-quality services, and in developing greater understanding of the working relationships between service professionals and service managers. Huw has published widely in each of these areas.

**evidence for
better health care**

nuffieldtrust

For more information about the Nuffield Trust,
including details of our latest research and analysis,
please visit www.nuffieldtrust.org.uk

Download further copies of this literature review
from
www.nuffieldtrust.org.uk/publications

Subscribe to our newsletter:
www.nuffieldtrust.org.uk/newsletter

Follow us on Twitter: Twitter.com/NuffieldTrust

Nuffield Trust is an independent
health charity. We aim to improve the
quality of health care in the UK by
providing evidence-based research
and policy analysis and informing
and generating debate.