

Physician Participation in Health Service Management: Expectations in United States and Experiences in England

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Increasing governmental regulation such as called for in PSRO and health planning legislation, pressures to contain rising costs, physician strikes, and other manifestations of change suggest that traditional hospital organization and management patterns ought to be re-examined. Moreover, as the United States moves toward a governmentally financed and regulated system, experiences in Great Britain and other nationalized systems become more pertinent to us. The 1974 major reorganization of the British National Health Service provides for considerable physician participation in management. A similar participative approach to the management of the hospitals in the United States is worthy of consideration as a way to meet increasing challenges of a governmentally financed and controlled health care system.

In arguing for physician involvement in hospital management the 1968 report of the Secretary's Advisory Committee on Hospital Effectiveness (United States Department of Health, Education, and Welfare, 1968:20) related the following fable to emphasize their point:

An intelligent visitor from Mars was interrogating a hospital administrator on the purposes, functions and management of a hospital. The Martian was told that the doctors in the hospital order the procedures for patients and thus determine how the resources are used, what work members of staff do and also decide which patients to admit and when to dismiss them.

"And where do these important persons stand in your operation?" the man from Mars asked.

"Actually, they stand outside the organization," the hospital administrator explained. "They are paid by our customers and they must observe certain rules, but by tradition the hospital must not interfere or seek to influence their decisions."

"You must be joking!" the visitor exclaimed. "As anyone can plainly see such an arrangement would be impossible to manage."

The administrator acknowledged that it was not easy.

The intelligent visitor was heard to mutter as he departed, "Impossible...or very very expensive."

The Commission on Health Manpower and others have argued for physician participation in hospital management decisions as important to containing the rise in hospital costs (National Advisory Commission on Health Manpower, 1967: 63-64). Since these reports, however, utilization review requirements have put increased responsibility for hospital costs on physicians. Nevertheless, in 1974 a bill was introduced into Congress (HR 13461) that called for doctors to share in any savings on hospital costs as an incentive to help control them. Reasons other than cost containment have been suggested for physician participation, such as it would help improve relationships within the hospital.

The American Medical Association has promoted the participation of physicians in hospital management by asking for the membership of physicians on the Hospital Governing Board, this request being endorsed by the American Hospital Association in 1973 after years of deliberation.

Reasons for Physician Participation

Management decisions must be distinguished from clinical decisions in which there is essential autonomy for the physician, either individually or collectively through the specialty organization. The physician who participates in management might discuss, deliberate, and help decide major issues such as:

1. The definition of hospital goals and plans, evaluating the success in achieving such goals through review of financial and other management reports.
2. Allocation of resources, whether these be financial, facilities, or manpower.
3. Obtaining resources through fixing the level of charges and determining the facilities to be provided.
4. Certain personnel decisions such as a selection of key administrative staff.

Although the control of rising costs has been said to be a major reason for involving physicians in administration, there are other reasons which do not directly involve expenditure. For example, physicians seem to be concerned about the growing power of hospital governing boards and administrators and want a greater voice in administrative decisions. In her warning about this, Betty

Jane Anderson (1973:4), of the office of the General Council of the American Medical Association, placed particular emphasis on the dangers of lay administration:

In some institutions, the situation has become so grave as to create a line of authority that goes from the attending staff to a salaried medical hierarchy which in turn is responsible to a hospital administrator often styled as president of the hospital and frequently not only chief hospital executive, but the dominant voice on the hospital governing board. In the institutions where the hospital administrator occupies the role of hospital president and chairman of the hospital governing board, the only line of communication between the governing board and the medical staff is through him. This is lay domination at its zenith a trend that should be aborted as early as possible.

While instances in which the hospital administrator also serves as chairman of the board would be most unusual, concerns about administrative dominance are real.

It has also been suggested by physicians in hospitals that there is a conflict in goal priorities with the physician concerned about the provision of service to the individual and the administration concerned with maintenance of the organization as a whole (Goss, 1963:180). Consequently the physician may be accused about lack of concern with the welfare of the hospital and likewise the administrator and board accused of lack of concern about the welfare of the patient. Participative management is recognized as fostering goal conformity and promoting understanding of the problems faced by others in the organization.

It is expected by national policy makers that an important major result of the involvement of physicians in management will be to help control hospital costs. Some of the ways in which this might be brought about can be summarized as follows:

- (a) The physician might be more concerned than the administrator or trustee about the cost to the patient with whose financial situation he may be more familiar.
- (b) By understanding the overall problems, the physician might be more supportive of management efforts to reduce costs.
- (c) He might become more aware of the financial results of unnecessary utilization of beds and ancillary services.
- (d) Participation in decisions regarding allocation of funds and other resources might bring about a more realistic evaluation of requests for more staff, equipment, and new

services, and a greater willingness to veto extravagant requests. Lay boards and administrators frequently find it difficult to refute a claim from a physician, nurse or other professional who states that a new service, higher staffing levels, or more equipment will improve quality or that "patients may die" if they do not get what they want.

Reasons Against Physician Participation

Although it is hoped that the main results of physician participation in management will be beneficial, it is possible to see how it could lead to difficulties.

1. It could diminish the influence of administrators, governing board members, and individual physicians by placing unusual power in the hands of a few physicians.
2. The involvement of a practicing physician in management might bring about goal conflict, thus weakening his professional standards when dealing with an individual patient.
3. It could result in more overall goal conformity but thereby minimize constructive conflict which might promote change.
4. It might bring about cost increases even more rapidly than at present. Arguments to support this point of view can be summarized as follows:
 - (a) By participating in management activities a physician will have less time to spend on patient care.
 - (b) Physicians are frequently believed to be poor managers as their training and orientation is an antithesis to a management role.
 - (c) A physician participating in budget matters might use his influence to extract even more costly services and facilities, as it is frequently claimed that the physician is oriented toward a maximum service for his patient irrespective of cost.

A search of the literature found many opinions about physician participation, but no empirical evidence that would shed light on these questions. In 1971, Schulz (1972) surveyed administrators in Illinois and Wisconsin regarding medical staff membership on governing boards and medical staff participation in decisions related to reviewing hospital income and expense statements, budget preparation, selection of key personnel, remuneration of hospital-based specialists, and facility plans. While he found increasing numbers of hospitals had physician membership on gover-

ning boards, such membership appeared to be concerned more with representing medical staff interests rather than active participation in decision activities. In the few cases where there appeared to be extensive participation, there was no statistical evidence of major differences in utilization of hospital services or hospital cost indicators.

The British Experiment

While there appears to have been little experience with physician participation in the United States, for reasons described later, Great Britain has recently (i.e., from April 1, 1974) reorganized its health service with physician participation in management as one of the major objectives. (While objectives of reorganization were similar for England, Wales, Scotland, and Northern Ireland, each has distinctive characteristics. Characteristics described refer to England, unless otherwise noted.) The plans and some limited experience in Great Britain may be of interest to those in the United States wrestling with similar issues. Moreover, with the enactment of the National Health Planning and Resources Development Act (P.L. 93-641) in 1974 an organizational structure and planning process seems to emerge in the United States which bears some resemblance to the reorganized British National Health Service. We describe below the reorganized National Health Service (NHS) and will also expose some of the substantial differences between it and the United States medical delivery system. For a description of other facets of the reorganization see Battistella and Chester (1973).

The organization of the NHS had to take account of the existence of three major groups of physicians, that is, the hospital-based specialists, the community-based general practitioners, and the public health doctor whose role has been enlarged to a specialist in community medicine. Throughout England and Wales there are approximately 20,000 general practitioners, 10,000 hospital specialists, 1,500 specialists in community medicine, and in addition to these three groups 15,000 junior hospital doctors in training grades (i.e., interns and residents).

It is the British preference to build on the existing institutions as much as possible. Although this has been criticized as merely putting new wine into old bottles and preserving for longer than

necessary deadwood that can be swept away (for example, the preservation of a separate organization for general practitioners), there is the major advantage that the changes have often been accepted by the participants if they could continue to formally play their old roles. Many levels of management are incorporated in the reorganization. At every level there is the participation of the three major groups of physicians and to a lesser extent participation by house staff. The system takes into account that the medical input will be greatest at the operational level, while economic, political, and social implications will predominate at the national level. For that reason the role (i.e., the power and responsibilities) of the representatives of medicine must be different at the various levels.

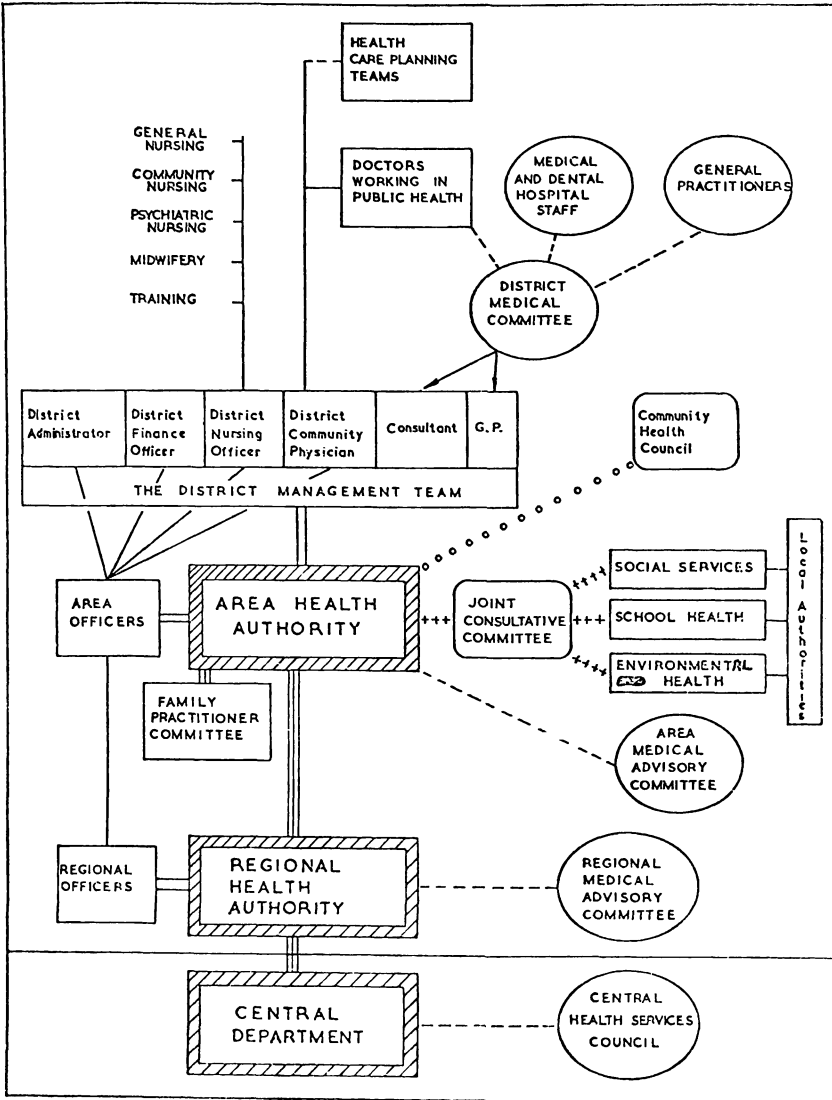
Physicians of all groups are to be involved in both an executive-management line and advisory machinery. The executive groups must be small, usually comprising six to nine individuals, whereas the advisory committees may be large and representative, consisting of groups of approximately 20 individuals. At an operational level the physician members of the executive groups are elected by their colleagues, whereas at the national level this would involve an elaborate or cumbersome electoral machinery; the medical officers at such levels are therefore appointed by the democratically elected national government.

The Machinery of Participation

The division of the country into regions for health administration (first introduced in 1938) has been continued. In England there are 14 regional health authorities, which are responsible to the Department of Health and Social Security (DHSS). The regions are divided into 90 areas which are further subdivided into a total of 205 districts. The district is the operational unit, serving a population of about 250,000 people and providing all health service facilities, including a general hospital under the control of a district management team. See Fig. 1 for the organization chart of the English National Health Service.

The District Organization

The District Organization is shown at the top of Fig. 1. A detailed description can be found in *Management Arrangements for the Reorganized National Health Service* (Department of Health and Social Security, 1972).



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FIG. 1. Organization Chart of Some of the Structure of the Reorganized National Health Service in England

The Organization of General Practice A district may be served by 100 general practitioners, and although some remain in solo practice, more and more are working from health centers in group practices supported by nursing and social work professionals and basic laboratory and X-ray services.

The traditional representative organization of the general practitioners has been the Local Medical Committee (LMC). This is a group of about 20 elected representatives. In this committee practitioners will discuss their views and attempt to reach decisions about how they would like to practice. There is no direct control over general practitioners, as they are legally independent contractors to the National Health Service.

The Hospital Organization Every district will normally be served by a District General Hospital, which may have 600 beds staffed by about 150 physicians, a third of these being permanent specialists (called consultants in Britain) who have full clinical control of the beds allocated to them and their corresponding outpatient departments. The other two-thirds are in training grades generally comparable to interns and residents in the United States.

Although the latter group is numerically larger, the effective share in medical management is much less. The house staff are transients, mainly concerned with training, and they may not have a hospital specialist career as an ultimate aim. Whereas the basic medical organization for general practitioners is the geographical district, the Local Medical Committee being elected by all doctors within it, the basic unit of organization within a hospital is the "Division" which has emerged fairly generally over the past 10 years (Department of Health and Social Security, 1974a). The division is not an elected body but comprises all specialists working in closely related fields (i.e., all surgeons, all internists, all pediatricians, etc.). One should expect to find in a large district general hospital from five to 10 such divisions. A teaching hospital may have additional divisions of education and research which tend to cut across more traditionally defined clinical areas. Each division elects its own chairman. It discusses matters concerning the work and interests of its members (it must be noted that in most British hospitals specialists are strictly separated from their colleagues in other disciplines). They have their own wards, are supported by their own nurses, and their own house staff. Divisions are responsible for defining developments in terms of expenditure, capital building, and manpower but do not have the authority for implementation of such policies. Recommendations and requests from the divisions are passed to the next level of medical participation, the so-called Medical Executive Committee (MEC) which comprises the chairmen of all divisions. The chairman and

vice-chairman of this Medical Executive Committee are not elected by members of the committee itself but by all the consultant staff of the hospital. This is an attempt to fulfill a major recommendation that the administrative work load of physicians be spread as much as possible. It is considered that the chairman of the MEC would be unable to cope with the additional work load of a divisional chairman. The MEC chairman is elected for a period of five years, whereas the divisional chairmen are usually elected for a period of two years. Chairmanship of the medical executive committee necessitates a considerable amount of time devoted to administration. It is thought that there is an increasing tendency for physicians based in service departments such as pathology or radiology to play a more active role in administration than their colleagues in the "bedside" specialities, where the work load is less predictable and the allocation of time for administration correspondingly more difficult. The chairman of the MEC is supported in his task by the provision of special office accommodation, full-time secretarial help, and a reallocation of his work among colleagues without loss of income. It is customary for senior representatives from nursing, finance, and administrative departments to attend the meetings of the MEC as observers, thereby supplying information vital to decision making. The main functions of the MEC can be summarized as follows:

- (a) It decides priorities on claims for additional medical staffing.
- (b) It coordinates recommendations and requests for equipment and facilities from the divisions.
- (c) It authorizes the allocation of study leave for medical staff.
- (d) It may act on occasions as a disciplinary body.
- (e) Perhaps most important of all, it provides peer control over claims for drugs and equipment. It is the task of the MEC to allocate priorities for these two items within a budget which is given by the management. It has become the practice for the MEC to draw up a list of drugs which can be prescribed without restriction. Drugs not on that list can still be prescribed but only with prior approval of the MEC on the basis of a recent application. In other words, presumably clinical freedom is preserved while there is a check on ill-considered prescribing.

The overall function of the MEC is the determination of priorities of manpower, equipment, and drugs in a

situation of limited resources. Practical experience has shown that when such decisions are made only by lay administrators they readily succumb to the threat of dire consequences by demanding clinicians.

In the United States, of course medical staff organizations are primarily concerned with quality control. It must be pointed out that in England this is not so; there is almost no quality or utilization review at the current time.

The District Medical Committee The next level of medical participation is the District Medical Committee (DMC) which is meant to be an instrument where the views of general practitioners and hospital specialists can be synthesized into a medical view. It also provides a voice for the third major medical group, i.e., the community physicians. It must be stressed that the constitution of this and the other medical committees to be mentioned later have been worked out by the medical organizations themselves and have subsequently been approved and incorporated into the official guide issued by the DHSS (Department of Health and Social Security, 1974b).

The DMC will normally have fifteen members, the size balancing the need for effective functioning with satisfactory representation of the main branches of the medical profession.

It will be composed in equal parts as follows:

- (a) Normally five general practitioners selected by the LMC, also to include general practitioners in training.
- (b) Normally five hospital-based physicians selected by the MEC, also including house staff.
- (c) A similar number of community physicians and physicians concerned with medical education.

The DMC elects its chairman and the vice-chairman of whom one has to be a hospital specialist and the other a general practitioner.

The District Management Team The next stage in the decision-making process is to integrate the view of the DMC, in itself a synthesis of the not always reconcilable, strongly held views of the main parts of the medical profession, into a decision-making group which will take account of the administrative and financial problems involved—together with the views of the other major health care professions. This is the task of the District Management Team (DMT).

The DMT consists of six members and is composed as follows:

•The chairman and the vice-chairman of the DMC, i.e., one specialist, one general practitioner, are automatically members of the DMT for the time they are holding their functions in DMC. This enables them to bring to the DMT the views of their medical colleagues and explain the reasons for them. They can make clear to the other members of the DMT what physicians would like to do and what they are not prepared to accept. This, so it is assumed, may prevent a management decision unacceptable to physicians which may even lead to a confrontation and a breakdown of health care. They remain active clinicians who continue otherwise in their normal role of patient care. Indeed, their credibility with their colleagues rests on this fact. They are part-time managers giving up, normally, only a few hours a week so that they cannot be considered by their practicing colleagues of "having gone over to bureaucracy." They are being compensated for this managerial activity by an honorarium currently about \$2,000.

•The District Community Physician is appointed by the Area Health Authority and is not an elected representative of his colleagues. This is a key role to help achieve objectives of the reorganization for identifying needs and integrating health resources to meet needs. It has been constructed in the reorganized service from two main sources:

- (a) The former Medical Officer of Health, which all local authorities in Britain have had by statute since the nineteenth century and who was broadly responsible for all public health matters, including vaccinations and control of epidemics.
- (b) The Senior Administrative Medical Officer, who since 1948 has been in charge of all hospital planning and medical staffing.

As a new concept which still needs further elaboration in practice, the District Community Physician (DCP) is intended to be a new medical planner and adviser trained in all branches of public health including epidemiology, information systems, etc., and also in such behavioral disciplines as organization theory and social administration. It is anticipated that he will function effectively as a medically trained intermediary between his colleagues in clinical practice and health service managers. It is noteworthy that his role has been recognized from the point of view of the new arrangement as the equivalent status to that of a hospital specialist. He is being

represented at all levels of the reorganized service and may often be a specialist in a particular field of community medicine such as child health, environmental health, capital planning, or medical information and research.

- The District Nursing Officer with responsibility for both hospital nursing and nursing services in the community.
- The District Finance Officer who co-ordinates the preparation of budgets, monitors effective use of resources, and provides financial advice to both the DMT and the DMC.
- The District Administrator, who may have previously served in a role roughly comparable to that of a hospital administrator in the United States and who is responsible for the full administrative and clerical staff in the district in all facilities and services, including the running of the district general hospital, health centers, etc.

The basic principles of the decision-making process of the DMT could be summarized under two headings:

- There is no imposition of a permanent chairmanship. All members are considered to be co-equal partners. They are fully entitled to elect their own chairman if they so wish, and they may even prefer to elect a new chairman for each session according to the expertise which the particular problem may demand.
- Decision making is based on the principle of "consensus management." This means that all six professional members including the two clinicians must find any proposal acceptable before a decision is reached. If any one of the six objects, no decision is taken. In this case the organization provides that the matter may be referred up to the next level of management, i.e., the Area Health Authority, normally composed of about 15 "trustees" (in the American sense), appointed by the region, who can reach a decision by simple majority vote. The main task of the DMT is to coordinate the medical information coming from the DMC with the proposals coming from the Health Care Planning Teams (which are multi-disciplinary and relate directly to community needs) and from other sources so as to work out a district plan determining priority within

a multi-professional framework.

Health Care Planning Team (HCPT) Medical participation in health service planning is now also provided for quite separately from the professional machinery in so-called Health Care Planning Teams (HCPT). It is proposed to set up such teams in every district oriented toward major client groups—for example, for planning the services for the elderly, for children, the mentally ill, and the mentally defective. The composition of these teams is meant to be very flexible but unquestioningly specialists in these particular disciplines are given a prominent place and will clearly play a predominant role with their colleagues in general practice, nursing, social work, etc. It is envisaged that the District Community Physician will play a major role in the coordination of the Health Care Planning Team.

The Area Organization

While the District Management Team is in charge of the Operational Unit, it is on the other hand part of the NHS, and its decisions have to fit into the broad national pattern. This is the main purpose of the hierarchical structure which is being built up for the whole of the Service. In the new organization decisions are first scrutinized by the Area Health Authority (AHA) which attempts to make sure that the district decisions fit into a cohesive area pattern and that priorities are appropriately determined and facilities adequately distributed.

Again there is an input by the medical profession in various ways:

1. The final authority in the area (the AHA itself) consists of about 15 *voluntary members*, as has already been stated, and normally includes a consultant and a general practitioner who, while in no way democratically representing the profession, will nevertheless make the medical viewpoint available.
2. The *professional advisors* of the AHA are the area team of officers: this is composed of four chief officers including the Area Medical Officer (who is a specialist in community medicine) and who is supported by at least three other specialists in community medicine with specific responsibility for child health, communicable diseases, and social services.
3. The Area Medical Advisory Committee is composed of 20 to 30 members representing all branches of the medical profession in

that area. About a third are general practitioners, including general practitioners in training, selected by the Local Medical Committee. There is an equal number of hospital-based doctors including at least one member of the house staff. Other members will be one or more community physicians selected by their colleagues in the area and up to three representatives of medical educational interests, such as postgraduate training, training for general practice, and the undergraduate medical school.

This committee is not concerned directly in management. It is an important means by which the local physicians may be consulted on crucial planning issues and can make their voices heard.

The Regional Organization

The decisions of the AHA again have to be ratified with their corresponding Regional Health Authority (RHA). Each of the 14 RHAs receives medical input for its decision making in a way similar to the area:

1. Through the membership on the Authority of 1 or 2 physicians
2. Through the Regional Medical Officer and his staff of specialists in community medicine
3. Through the Regional Medical Advisory Committee, which consists of representatives of the medical profession determined partly on geographical considerations and partly on the specialities within the region. Its members will be either the chairman or vice-chairman of each of the Area Medical Advisory Committees, together with representatives of hospital house staff (selected by the hospital house staff themselves within the region), community physicians (selected by their colleagues within the region), and representatives of undergraduate and postgraduate education. Regional specialist subcommittees (e.g., in laboratory services, psychiatry, and general practice) will be formed by the profession themselves and the chairman of each subcommittee will sit on the Regional Medical Advisory Committee. The Regional Health Authority and its officers will thereby gain medical advice on crucial issues of planning and the distribution of specialities and manpower in particular.

The National Organization

National policy for the NHS is ultimately, since Britain is a democracy, in the hands of an elected official responsible to Parliament—the Secretary of State for Health and Social Security. Very rarely in England has this official been a physician. On the

other hand the medical profession is strongly represented in influencing the decisions which the Secretary of State finally reaches:

1. *The Chief Medical Officer.* Since the middle of the nineteenth century, when the health of the nation became of vital public concern, a physician was charged with the task of advising the Minister responsible. The Chief Medical Officer today is in control of a very substantial department of qualified doctors who themselves are specialists in all topics concerned with the health of the nation. These Medical Officers of course have close contact with the clinical branches of the profession and administrative officers of the DHSS. Rarely is a decision formulated without detailed professional consultation.
2. *The Central Health Services Council (CHSC).* Direct consultation between the DHSS and the medical profession takes place within the CHSC which has been in existence since 1948. The CHSC is composed of elected representatives such as the presidents of the Royal Colleges, the chairmen of the British Medical and Dental Associations, and eight other medical practitioners, together with dental, nursing, pharmaceutical, and social work professionals, other persons with experience in health service management, and those representing the point of view of the public. The CHSC appoints several standing or ad hoc Medical Advisory Committees, which will discuss a wide range of topics such as cancer research, organ transplantation, alcoholism, screening in medicine, etc. The profession through the CHSC advises the DHSS in its production of national policy guidelines.

The Machinery in Practice

1. The machinery described is very new. Clearly it will take some time before the participants will grasp the full implications and thus before a smooth-running process develops. Moreover this running had been delayed in the first year owing to the financial difficulties which have affected the operation of NHS and brought in its wake a confrontation of the hospital specialists with the government.
2. The National Health Service is a large and complex organization, and any machinery for effective participation by the physicians is bound to be complex. The physician working at the bedside still feels that he is a long

way from what he perceives to be the point of ultimate administrative decision. There seem to be too many levels between him and those who have the actual power. As a result, the decision making is rather slow.

3. There is also the difficulty of *keeping in touch with one's elected representative*. Feedback is relatively easy from the specialist to his hospital-based colleagues through a well-developed divisional system. However, the house staff member on the DMC frequently finds it difficult to communicate with his colleagues. Thus, there is still a widespread feeling in the medical profession of remoteness from decisions which vitally affect it. Personal involvement is as yet an elusive goal.
4. It is obviously difficult for specialists or general practitioners to find the *time* to participate in administration while continuing active clinical duties, although it is imperative that they achieve this in order to retain their credibility.
5. A number of voices have criticized the whole idea of team management and would have preferred a system of individual management by a chief executive. It is indeed suggested that team management may "wither away" in practice as strong personalities emerge in the team who will arrogate to themselves leadership and unrestricted decision making. It will be interesting to watch whether these forecasts prove correct or whether the multi-professional approach may not turn out to be the method of the future (Howard, 1973).
6. So far we do not know if general goal conformity can be reached with the widely differing interests and aims of community physicians, general practitioners, and hospital medical staff. At the present time the hospitals have a major and disproportionate share of both staff and financial resources, whereas preventive medical services are extremely undersubscribed.
7. There is finally the fundamental question of *consensus* management itself which is leading to a number of as yet unresolved issues.
 - (a) Whereas a delegate involved in political negotiations has to

take a line predetermined by his colleagues, a representative in a consensus group must be given freedom to exercise his own judgment while nevertheless protecting the interests of those he represents. This is a situation to which the medical profession has not yet adjusted itself.

- (b) Practicing clinicians have now been given a managerial voice equal to that of professional administrators. They may feel themselves outnumbered by the four officers of the DMT, viewing the community physician and the nursing officer as part of the administrative establishment. However, the administrator and finance officer could also feel themselves to be in a minority of four to two, viewing the community physician and the nursing officer as a clinical group with the consultant and general practitioner. As participants become more familiar with the workings of consensus management, the concept of numerical inferiority should become less and less relevant.
- (c) When the consensus principle was originally proposed, many people concerned with the administration of the health system felt sincerely that this would be disastrous. After all, what it would mean in practice—so they expected—would be that every professional in turn would exercise his veto so that, instead of efficient decision making, there would be eternal wrangles and at best log-rolling.

Although two years is too short a time for reaching definite conclusions, it can be stated that these woeful forecasts have not come to pass. It might have happened that controversial decisions were deferred from further consultations by the District Management Team, but formal vetoes recording irreconcilable disagreement have been very rare indeed. The reasons for this outcome have been the fact that the DMT, in spite of their heterogeneous professional backgrounds, welded themselves fairly quickly into organic entities. The regular meetings, very often underpinned by common meals, led to greater friendliness and understanding, so that very soon no individual member was anxious to incur the odium of pronouncing a veto which would mean that the decision was taken out of the management team and referred above to the Area Health Authority. Social forces and group behavior seemingly are stronger than organizational constraints.

Implications for the United States

To an American observer it appears that physician participation in management decisions is a good move in England under a nationalized system with very limited resources. Is it to be recommended for the United States? In the recent past it was probably not a feasible alternative. Medical staff members were, by and large, independent individuals and a lay administrator was less a threat to such independence than a physician who took or helped to take responsibility and accountability. Moreover, many physicians in the United States already feel too overburdened with quality- and utilization-review activities to spend more time in management committees.

Most administrators and boards in the United States have been quite receptive to requests for new services and facilities. Because it was possible to raise rates and because new services usually generated more income and prestige for the hospital and lowered unit costs of the departments, administrators and trustees did not need to raise questions as to whether or not the new service or facility really improved quality. Administrators, too, have not wanted participation or interference from others, for a major source of administrative power is control of management information.

The environment for hospital and health management is, however, changing rapidly in the United States. For example, the National Health Planning and Resources Development Act (P.L. 93-641) unifies planning, resource allocation, and regulatory efforts in the United States and increases federal control over local activities. Figure 2 presents the organization and responsibilities called for under this act. This hierarchically related network provides some striking resemblances to the framework of the English National Health Service.

Other trends also portend organizational changes in American hospitals. The independence of the individual physician is diminishing through utilization- and quality-review requirements. Physicians are also becoming more cohesively organized, as evidenced by recent collective bargaining activities and even strikes.

Hospital administrators and trustees too must make harder decisions on allocation of limited resources. Increasingly, decisions will need to be made as to where staffing might be reduced and even which services will be curtailed. Administrators and trustees are

**SECRETARY, U.S. DEPARTMENT
HEALTH, EDUCATION AND WELFARE**

- Issues guidelines for national health planning policy
- Establishes health areas recommended by governors
- Designates health systems agencies in each area
- Issues regulations governing implementation of the act
- Reviews health plans produced by substate and state agencies
- Administers grant programs to agencies
- Approves most federal assistance plans and project grants

**STATE HEALTH COORDINATING
COUNCIL (SHCC)**

(a consumer majority council of citizens 60% designated by HSA, 40% designated by the governor)

- Conducts health planning activities for the state
- Implements or supervises implementation of plans
- Prepares preliminary state health plan
- Serves as agency for (S.1122) review
- Administers a state certificate-of-need program
- Reviews and makes findings concerning all new institutional health services in the state
- Reviews periodically all health services offered in the state
- Coordinates all health data activities in the state
- Assists SHCC in its work
- Administers federally assisted facilities construction activities
- Administers optional rate review and approval programs

**STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY (SPDA)**

(a state agency designated by the governor to carry out activities mandated by the act)

- Reviews and coordinates health planning activities of substate agencies
- Prepares and approves state health plan
- Reviews and comments on annual budget of substate agencies
- Reviews and comments on annual applications of substate agencies
- Advises SPDA on its work
- Reviews and approves all state plans and applications for funds under federal health legislation

HEALTH SYSTEMS AGENCY (HSA)

(A public or private nonprofit agency with a consumer-majority board or advisory body which carries out functions mandated by the act in a defined geographic area. Areas are based on criteria defining minimum population and available health services to meet the needs of the areas residents.)

- Assembles and analyzes data on health status and health programs in its area
- Prepares and publishes a Health Systems Plan (HSP) and an Annual Implementation Plan (AIP) for its area
- Develops specific activities and projects which support plans
- Implements plans through technical assistance and through developmental grants to community agencies
- Coordinates activities with other planning bodies and PSROs
- Reviews and approves each use of federal health funds in its area
- Recommends action on each health service offered in area to state
- Reviews and comments to state agency on all capital expenditures and new service projects in area institutions
- Recommends health facilities projects to state for funding

COMMUNITY INSTITUTIONS AND ORGANIZATIONS

- Submits all new service and capital expenditure projects for review
- Participates in periodic review of existing services
- Submits all applications for federal support for review
- Conducts special projects under developmental grant authorities

Source: Schulz and Johnson (1976: 265).

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FIG. 2. Planning, Organization, and Responsibilities under P.L. 93-641, National Health Planning and Resources Development Act.

likely to want physician participation in such decisions.

With increasing influence of Health Systems Agencies, the hospital governing board's role as the link to the hospital's environment becomes less important. In that case hospitals may in the future find internal boards composed in a large measure of physicians and key administrative and professional personnel to be more effective than community representatives (Schulz and Johnson, 1976: 47-65).

Assuming that controls over hospitals and needs for greater control within hospitals will increase, the advantages of the traditional organizational arrangement in U.S. hospitals of almost separate medical staff and hospital trustee, administrator, and employee organizations are diminishing. If such a divided organizational pattern remains, it may result in more formal collective bargaining and confrontation between the two organizations. If medical staffs and hospitals are to be integrated it seems quite plausible for a management team approach to be utilized. The other alternative is for an even more hierarchical approach with a full-time lay administrator or medical director as the chief executive officer, which Great Britain for one found unacceptable.

Experiences with participative management teams in Great Britain should be evaluated as to their effects on costs, quality, attitudes, and feasibility for adaptation to U.S. hospitals. Hospitals in the United States should experiment with such alternative approaches. Certainly traditional hospital organization patterns will need to be re-evaluated in light of health delivery system changes we are experiencing.

While we are in no way suggesting transplantation of the British organizational arrangement to the United States, we do suggest that a management team approach does have application in changing United States health delivery system. Further support for the team approach in the future is suggested by Ansoff (1973), who predicts that demands on managers of complex systems will exceed the capacity and comprehension of any single individual and will call for the concept of the corporate office which replaces the chief executive officer with a team of coequals. While Ansoff is talking about industrial management, his model seems to be particularly relevant to the hospital, which is already one of the most complex organizations in our society.

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