## MCQs

**1 The following cultural differences distinguish doctors from managers:**
a managers tend to use jargon
b doctors are good team players
c doctors focus on the individual
d managers have to move jobs to gain promotion
e managers focus on the organisation as a whole.

**2 Which group is least supportive of managerial modernisation initiatives?**
a trust board non-executives
b chief executives
c doctors
d nurse-managers
e financial directors.

**3 Managers and doctors have the following areas in common:**
a both professions have specialists
b both have long career paths
c both have an interest and expertise in finance
d both have ethical responsibilities
e both are skilled in navigating complex bureaucracies.

**4 Scapegoating is:**
a a desire to raise standards in the organisation
b a method of transferring guilt
c a recent phenomenon
d often associated with extra-punitive attitudes
e a magical way of dealing with guilt feelings.

**5 The doctor–manager relationship could be improved if:**
a both doctors and managers were educated about psychodynamic processes within an organisation
b interdisciplinary education were fostered early
c regulation of clinical activity by external agencies was increased
d greater managerial staff stability were ensured
e respect for differences between managers and doctors were engendered.

**MCQ answers**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| a F | a F | a T | a F | a T |
| b F | b F | b T | b T | b T |
| c T | c T | c F | c F | c F |
| d T | d F | d T | d T | d T |
| e T | e F | e F | e T | e T |

# ‘When we cannot act as we wish, we must act as we can’[1]

## Invited commentary on... The doctor–manager relationship

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The NHS is an organisation populated by groups who often compete with each other over sparse resources and avenues of influence. Professional rivalry is endemic in this situation as groups position themselves to acquire, consolidate and protect professional territory.

In order to communicate and position themselves, professions are obliged to use the discourses that have currency and validity in the wider system. This means using the new managerialist rhetoric of audit and accountability so dominant in the public sector. The rhetoric includes a clustering of terms familiar to anyone working in these services: ‘performance’, ‘targets’, ‘action plan’, ‘outcomes’, ‘empowerment’, ‘corporate’, ‘politically aware’, ‘risk management’, ‘stakeholder’, ‘evidence-based practice, ‘benchmarking’, ‘good practice’, ‘efficiency’, ‘effectiveness’, ‘quality control’, ‘accountability’, ‘external verification’, ‘transparency’, and so on.

1. Terence, *Andria*, 805: ‘Ut quimus, aiunt, quando, ut volumus, non licet.’



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In the UK, their origin can be traced to the Thatcher years and the increasing migration of the language of audit from the financial sphere to all aspects of our working lives (Shore & Wright, 2000: p. 60).

Unless professions and individuals within them employ this kind of rhetoric they may not achieve influence and may also be peripheralised. They then run the risk of being characterised as irrelevant or, if more powerful, as resistant and 'non-corporate'. The new managerialist rhetoric that I am describing therefore becomes a powerful and coercive tool with which professional identities and relationships are shaped. None the less, behind the scenes and despite the language of accountability and transparency, people go on doing what they have always done and probably always will do. That is, they are as likely as ever to fall back on primitive processes of relating, among which Garelick & Fagin (2005, this issue) identify scapegoating and projection. There are also the informal processes of organisational life, the 'who knows who' ways of getting things done and the importance of gossip as a vehicle for alliance-building (Elias & Scotson, 1994). In other words, I am here referring to the dynamics of power relations and the ways in which people position themselves and others as insiders or outsiders, the phenomenon that Garelick & Fagin mention briefly as 'them and us'.

## Them and us

The 'them and us' issue is particularly pertinent to the NHS, given its complex proliferation of professional identities and interests. Of course, doctors and managers are not unique in their positioning of each other in this way. The same dynamic potentially operates between all groups, since it helps achieve cohesion. Cohesion in group terms is crucial and may be linked to survival and the unconscious anticipation of a task that may require a fight or flight response. Cohesion within one group is therefore often achieved at the expense of another group. Gossip within groups about other groups frequently contains themes that confirm to the interlocutors their sense of belonging and alliance. Such themes might be articulated as 'They are different from us and a bit suspect – they are outsiders. We are similar and somewhat better – we are insiders'.

The rise of the culture of new managerialism is central to an understanding of the dynamics of doctor–manager relationships and the way that it exacerbates the inherent 'them and us' dynamics of intergroup behaviour. The language of empowerment and devolvement thinly disguises an increasing tendency for centralisation and control by a government whose own targets include re-election on the back of 'continual improvement' of public sector services. The aim is that workers internalise the discourse of audit and become self-governing units and accounting commodities. So internalised has this discourse now become that it seems to many to be common sense and unquestionable.

## Control and divide

So what is wrong with all these proscriptions for governance and accountability? First, health service staff are not truly 'empowered' to work with anything outside of a very narrow set of centrally determined references. Meaning is therefore taken away from the 'vested interests' and 'cosy circles' of local professional groups and is derived from politically driven government objectives. This tends to demoralise individuals, whose work tasks can begin to feel meaningless and irrelevant at a local level since all meaning is derived and legitimated centrally. Furthermore, the emphasis is on systems of control rather than, for example, the complexities of doctoring. As Power (1994: p. 19) puts it:

> 'What is being assured is the quality of control systems rather than the quality of first order operations. In such a context accountability is discharged by demonstrating the existence of such systems of control, not by demonstrating good teaching, caring, manufacturing or banking.'

The interprofessional divide that so often separates doctors and managers also functions as a defence of independence and autonomy. A boundary of non-communication and non-engagement helps to protect the status quo. New managerialism challenges the traditional power structures of the medical profession and in some situations has brought about a crisis in role for the latter, especially in terms of leadership and authority within teams. Doctors who become managers (the reverse is probably a rarity) run the risk of being treated like collaborators with the enemy. Considerable emotional labour is required of those asked to straddle the split.

## Mutual sense-making

So what is to be done? Garelick & Fagin highlight some examples of useful interventions. In all of them, managers and doctors are obliged to talk to each other both in a formal sense regarding a task but also, presumably, less formally over their coffees and lunches. My point is that both groups require ongoing opportunities for dialogue which must extend beyond the positioning and constraints of highly structured committee meetings. In other words, the opportunities for dialogue must be



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complex and allow for different avenues through which the working relationships can develop. Owing to the power dynamics between the groups, it is helpful to invite experienced facilitators to some encounters. This offers an opportunity for the development of mutual sense-making as opposed to parallel universes.

## References

Elias, N. & Scotson, J. L. (1994) *The Established and the Outsiders*. London: Sage.

Garelick, A. & Fagin, L. (2005) The doctor–manager relationship. *Advances in Psychiatric Treatment*, **11**, 241–250.

Power, M. (1994) *The Audit Explosion*. London: Demos.

Shore, C. & Wright, C.(2000) *Coercive Accountability*. In *Audit Cultures* (ed. M. Strathern). London: Routledge.

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