Section B. *Should* but *Can* Not Become a Profession

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The Professionalization of Medical Management? The Slow and Chequered Case of UK Health Care

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Introduction

Health care was the site for the development of an outstandingly successful profession, namely medicine, in the mid-nineteenth century. More recently, nursing has engaged in a similar "professionalization project", although with limited results. Other aspirant groups (midwives; health visitors; physiotherapists) constitute a complex system of health care professions, trying to build up their own turf and jurisdictions (Abbott 1988; also see Montgomery 2013 for a recent overview of the development of various health care professions). So historically, health care has been both a highly and also multi-professionalized sector.

The question explored here is: *is medical management developing as a new profession in health care?* The term "medical management" implies the management function is undertaken by doctors (and nurses) taking on hybrid clinical–managerial roles; conversely, *not* undertaken by lay (or non-clinical) general managers. Since the 1980s, repeated policy-driven

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attempts tried to upgrade management capacity in increasingly expensive health care systems (see Pettigrew et al. 1992, on the UK; Scott et al. 2000, on the US), so the question of where any enhanced management function "falls" is important.

This chapter will, firstly, review some academic literature to orientate the discussion theoretically. It will, secondly, briefly explore the history of national policy towards medical management in the UK's NHS (National Health Service). It will, thirdly, benchmark UK developments against findings from comparable US studies (Montgomery 1990; Montgomery and Oliver 2007). It concludes with broader reflections about possible reasons for the slower professionalization of medical management in the UK than the US and some wider implications of the analysis developed here.

Normatively, it is here argued that the professionalization of medical management would be a positive development from a societal and public interest perspective. This view suggests professions are—at their best—associated with an ethics code and the inculcation of a sense of vocation. Professions also often seek to develop a systematic knowledge base to inform practice, diffused through educational credentials. They should be sensitive to the quality of services delivered to their clients as well as cost. These traits are as useful in ensuring the more trustworthy, client-facing and knowledge-informed management of complex health care organizations as in front-line clinical practice. These qualities could also rebalance the agendas of health care organizations to prevent capture by over-narrow financial objectives. The professionalization of medical management is to be welcomed normatively; however, the empirical evidence suggests progress is mixed or even slow, notably in the UK. These arguments have obvious implications for other health care systems internationally but they could well also have wider repercussions for the style of management that may be preferred in a wider and important set of other professionalized or knowledge-based organizations, notably including law, accounting, universities, science-based firms and management consulting.

Academic Literature: Sociology of the Health Care Professions

Sociologists of the professions (Freidson 1970, 1985; Larson 1977) have been fascinated by the health care sector as it produced historically high levels of professional control, although recently this pattern has been challenged. The possession of an expert body of knowledge inaccessible to outsiders is a key claim that professions make, associated with a strategy of credentialism (Montgomery 1990). There is typically a claim for self-regulation rather than imposed external regulation from lay outsiders. Clinical professionals are socialized into the profession through a long and intensive education, originally as a student in medical school.

Such professional dominance exerted strong effects at the organizational as well as at the patient level. Classically, modestly styled "administrators" in professionalized organizations—including hospitals—displayed an indirect and facilitative form of management (Mintzberg 1983), with senior clinical professionals forming an operating core. Successful professions achieve market closure and construct a labor market shelter, controlling market entry and exit by individual professionals, and also insisting on educational credentials. They also self-regulate, for example, through the UK royal colleges in the case of medicine.

This traditional professional dominance model (Freidson 1970) was challenged by New Right governments of the 1980s, including those led by Ronald Reagan in the US (Scott et al. 2000) and Margaret Thatcher in the UK (Ferlie et al. 1996). The objectives of New Right health care reforms were to: contain cost escalation; increase transparency; empower health care consumers or their proxies and strengthen market forces and user choice. This New Public Management (NPM) reform recipe combined building stronger markets *across* the health care sector with more assertive lay management *within* health care organizations (Ferlie et al. 1996).

Some writers speculated about the radical deprofessionalization of health care (Haug 1988). One implication was that power would shift from clinical professionals to a new cadre of general (lay) managers. A second and more nuanced argument was that the medical profession

would display internal restratification (Freidson 1985) so that a new medical management elite emerges from within the profession rather than from outside it. One question is whether this new hybrid elite would still support professional control or become distant from the professional rank and file. Waring (2014) developed Freidson's initial typology, identifying (amongst others) a new corporate clinical elite as co-owners of equity in growing private sector health care organizations. Waring (2007) pointed to the resilience and adaptability of clinical professionals: his study of the local implementation of new patient safety systems suggested clinicians could regroup and claw back organizational territory from general managers in new and clinically dominated decision-making systems.

Against these arguments, two contrary considerations suggest medical management might struggle to professionalize. Firstly, while medicine underwent a rapid professionalization process around the 1850s, subsequent professionalization processes were slower, more contested or have stalled. Muzio et al. (2011) suggest that modern societies may be less receptive for profession building, given weaker basic values of social deference and trust which historically underpinned such processes.

Secondly, why should medical management professionalize when management as a broader occupational group has long struggled so to do? The longstanding UK Chartered Management Institute (for a description of current activities available on their website, see CMI 2017) has so far achieved little market closure. Reed and Anthony (1992) argue that dominant forms of UK management education are too mechanistic and intellectually weak to support management developing as a reflective, self-governing profession.

A Brief History of NHS Management Reforms

Historically, UK health care displays a largely publicly funded system and only a small private sector. As such, the NHS has been vulnerable to successive imposed top-down policy "reforms" (Klein 2013) from the Department of Health. Three policy initiatives with strong implications for NHS management will now be considered.

Up to the mid-1980s, a classically Mintzbergian (Mintzberg 1983) pattern of organizing within a professional bureaucracy was evident, which produced informal dominance by the health care professions (especially medicine). During the 1970s, a consensus management-based system involved medicine, nursing and administrative groups but implied only a modest role for "administration". Clinical groupings could easily veto unwanted change. During the 1980s, there was an increasing political perception that the NHS was immobile, unable to progress top-down demands for rapid retrenchment (e.g. hospital closures).

The Griffiths Report (Griffiths 1983) led to an important NHS management reform strong (lay) general management, introduced in the mid-1980s. Griffiths argued empowered general managers would increase the local drive needed to achieve national policy objectives and reduce large implementation gaps (Pettigrew et al. 1992). The initial focus was on attracting senior managers from the private sector, although this policy had very mixed success and in practice the new general managers were often younger NHS administrators who knew the sector. Pettigrew et al. (1992) found they generally welcomed a broader role and sought to progress strategic service changes, including accelerating the hospital closures demanded in national policy. They did not adopt a heroic or individualist leadership style, but often worked in small mixed teams, including with senior medical and nursing leaders.

Griffiths (1983) produced two less remembered but important proposals: more patient feedback and (of interest here) support for "getting doctors into management", with appropriate administrative support and better-developed clinical and financial information systems. The Department of Health sponsored local pilots to take this clinical management agenda forward.

A second major reform was the 1990 Health and Community Care Act, which replaced the old planning-based system by a quasi-market designed to mimic supposedly beneficial market forces. Although the NHS remained in public ownership, newly created and separate purchasing and providing organizations now related through contracts rather than hierarchy. On the provider side, the old directly managed hospitals became operationally independent NHS "Trusts" which in principle could compete for contracts from purchasers (although in reality the

quasi-market remained highly managed). The purchasers could let contracts to independent and non-NHS providers. This basic purchaser/provider split has endured since 1990, although with frequent—if often superficial—reorganization, especially on the purchaser side.

As the Act required hospital services to be costed, marketed, made more efficient and quality assured, so medical management capacity needed to be upgraded (as Griffiths 1983, earlier suggested). Clinical managers might well have greater knowledge of the key dimension of health care "quality" than lay general managers. A clinical directorate model pioneered in Guy's Hospital in London (borrowing from Johns Hopkins Hospital, Baltimore, US) (Coombs 2004) now spread widely across the NHS. They were usually led by a part-time clinical director who retained some clinical practice, but who worked closely with a senior nurse and a general manager/accountant in a triumvirate. Further clinical managerial hybrids emerged in the 1990s (Ferlie et al. 1996), including primary care physicians recast as clinical managers in new and more managed primary care organizations and also Directors of Public Health in purchasing organizations, tasked with assessing population needs and (hopefully) reflecting them in contracts with providers. In the early 1990s, these hybrid roles were new and supported by intensive educational and training programs but such investment tailed off.

A third and more recent policy text is Cm 7432 ("High Quality Care for All") (2008) which strongly supported the revival of *clinical* leadership, criticizing earlier general managerially led approaches that reduced clinical engagement and initiative. Lord Darzi led the writing of the report, being a junior minister in the Department of Health at the time (under the New Labour government) and also an eminent professor of surgery and a major health policy leader. Cm 7432 (2008) led to renewed policy activity and investment in clinical leadership, including in a cohort of so-called "Darzi Fellows" selected as younger clinical leaders and provided with a development program. Thus significant national resources were again made available for clinical leadership programs.

The Professionalization of American Medical Management

The professionalization of American medical management was examined by Montgomery (1990) and Montgomery and Oliver (2007). We will review both articles and benchmark their analysis against the UK case. Montgomery (1990) argued that the 1980s cost containment-orientated US health policy reforms opened a niche for a new managerial jurisdiction that might in principle be filled by clinical/managerial hybrids. As well as favorable structural conditions, subjective processes of resource mobilization were needed for this profession to develop, including: (i) "discovering colleagueship" or recruiting potential members and building a collective professional identity, and (ii) legitimacy building and creating an externally recognized jurisdiction.

Significant activity went back to the 1970s. In 1975, the American Academy of Medical Directors was formed (the title was itself significant in claiming a new identity). In 1979, it morphed into the American College of Physician Executives (ACPE), which acted as (Montgomery 1990, p. 189) the national professional accrediting association exclusively recognizing and certifying physician executives. The American Medical Association was supportive, giving the college (1984) a seat on its house of delegates and recognizing its educational programs.

ACPE sought recognition from the American Board of Medical Specialties (ABMS) as a new speciality but its requirement for "teachable and testable" knowledge was not easy to fulfil and this ambition remains unrealized. Various educational programs were offered by different universities in clinical leadership but with weak standardization and the College had little direct control over curricula offered.

Overall, there was found to be a mixed or an "uncertain picture". Structural conditions for creating a new jurisdiction of medical management were favorable and processes of resource mobilization underway. But "the prize was far from assured" (Montgomery 1990, p. 194) as: (i) the occupational identity was still unclear; (ii) a body of "teachable and testable" knowledge was not agreed and (iii) there was (and remains) no ABMS recognition.

Fitzgerald et al. (2006, pp. 169–70) benchmarked UK developments against Montgomery (1990), but saw only very limited progress. Hybrid roles were widely evident, but often narrowly concentrated on operational management and covering only one clinical specialty. There was limited attention to wider service improvement or change management issues. Day-to-day operational pressures could be overwhelming: "The conclusion is more pessimistic than much of the earlier literature which has assumed relatively broad role definition." There were major education and training needs and medical management in primary care was very weakly developed. There were problematic relations reported between clinical managerial hybrids and rank and file clinical colleagues.

When benchmarked against Montgomery (1990), "we again found evidence of only a very limited professionalization process" (Fitzgerald et al. 2006, p. 170) and again: "more fundamentally, the hybrid group does not yet have a coherent work identity or credentialized knowledge base" (p. 170). There was no formal recognition of medical management as a specialty. They found (p. 170): "Other medical professionals do not consider clinical management to represent a medical speciality, rather clinical managers uncomfortably span the managerial clinical divide and are not full or influential members of either occupational group." Many hybrids reported they did not want to remain in clinical management. Fitzgerald et al. (2006) called for more research into the "remainers".

More recently, Ham et al. (2011) studied a cohort of 22 current or former medically trained NHS CEOs, characterizing them as "keen amateurs" who were vulnerable in post and who needed more professional development. These CEOs were often motivated by the opportunity to undertake large-scale service improvement activity level. But they had generally received little structured advice or guidance and highly variable education and training opportunities. No one qualification was mandatory. Most abandoned clinical work given the pressured demands of the CEO role. Many reported shifting personal identities and now saw themselves as leaders who combined clinical and managerial experience as opposed to simply being clinicians. The high turnover of post holders could adversely affect their careers. Ham et al. (2011) benchmarked their findings against Montgomery (1990) and Fitzgerald et al. (2006), again suggesting slow UK progress (p. 118).

Montgomery and Oliver (2007) examined how a new social entity comes into being by constructing boundaries around itself. They developed a general four-stage process based model which they then applied to American medical management as a case study.

In a long Stage 1 (1950–1974), informal networking from a like-minded grouping of institutional entrepreneurs created a provisional institutional entity. As early as 1950, the American Association of Medical Clinics (AAMC) was founded as a representative body for relevant health care organizations (notably, large group practices), which then provided networking opportunities for clinic directors. A proposal to set up a body to represent these individuals was passed at its 1973 AGM. The American Association of Medical Directors (AAMD) was created in 1974 with only 64 founding members.

In a short Stage 2 (1975–80), this nascent grouping engaged in outward-facing activity to import new members and make initial domain claims externally. The AAMD quickly founded its own journal and put on educational programs with prestigious universities where nationally recognized management scholars taught. CME credits were secured from the AMA in 1976. The entity renamed itself as the American College of Physician Executives to broaden its appeal, modelling the approach of well-established medical colleges.

The critical Stage 3 (1981–1995) marks the period when a new social identity crystallized, coinciding with a rapid take-off in ACPE membership. This period combined intensive inwards facing (or centripetal) work in forging a group identity, alongside still making more domain claims externally (or centrifugal work). Montgomery and Oliver (2007) argued (p. 673): "evidence began to appear, by the 1980s, of a switch to centripetal forces to generate membership exclusivity and a standardized social identity". Fellowship awards were introduced (1981). More educational programs and credentials were established, partnering with leading universities. Their journal (*Physician Executive*) became refereed (1989). The group leadership (1987) called for a code of behavior and quality standards to be adopted by the association and all its members.

Stage 4 (1996 onwards) displayed a process of institutionalization when the new entity became a legitimate actor in the field and achieved stability. They conclude in a relatively optimistic manner: "the profession

of physician executive had been well recognized and taken for granted in the field" (Montgomery and Oliver 2007). Membership stabilized at about 10,000 members, their journal was indexed and refereed and they partnered with leading universities to offer masters in medical management. A new award of Distinguished Fellow (2001) provided a further credential, designed to celebrate individual achievements in clinical leadership (so publicly reinforcing a new identity amongst fellows).

More recently, the entity renamed itself as the American Association for Physician Leadership (see AAPL 2017). "Leadership" was now preferred as a broader and softer word than "Executive". Its journal was renamed the *Physician Leadership Journal*. AAPL offers extensive networking and career development opportunities.

We comment that there are limits to the American project's success: medical management is still not recognized by the ABMS as a speciality. A Masters in Clinical Management remains permissive and not mandatory and there is no standard curriculum. There is no requirement for a state license affirming clinical *management* credentials rather than clinical ones.

The UK Case: Slower Progress?

The British Association of Medical Managers (BAMM) (1990–2011) was the first UK national organization promoting medical management. It went into insolvency in 2011, not because of any wrongdoing, but for failing to generate secure income in difficult financial times.

An analysis of its filed annual accounts (Companies House 2017) suggests BAMM adopted aspects of a professionalization project: it sought individual membership subscriptions from clinicians and like-minded others (but this pluralism suggested weak exclusivity); it had a peer reviewed journal (*Clinician in Management*) originally published by an academic publisher but later renamed *Clinical Leader* (2009) and brought in house (so producing a lack of continuity); it produced other publications (but its annual reports indicate they were not easily written in practice); held an annual conference and offered day seminars (but no Master's program). There was no report of any elaboration of an ethical code.

These texts suggest many activities remained small scale, sometimes struggling to survive. BAMM's annual income was only about £1m.

BAMM was an important contractor in supporting NHS clinical management development (e.g. the "Fit to Lead" program). Its 2009 annual report indicated most income came from such project work rather than membership subscriptions. This NHS portfolio was jeopardized by substantial reductions in NHS management costs brought in by the new government (elected in 2010), which had given a broader pledge to limit government spending. BAMM quickly built up a financial deficit and went into receivership. As the Statement of Proposals from the appointed Administrator (2010) (Companies House 2017) put it: "The company had expected to have its financial situation relieved by the NHS filling its funding gap. However, following the general election, the newly elected government had announced restrictions in terms of funds available. The NHS carried out a review of BAMM.s operation and subsequently decided to withdraw funding."

The interpretation advanced here is that BAMM moved from Stage 1 to Stage 2 but not onto Stage 3. Liquidation instead marked a move back to Stage 1, where there is a network of supportive individuals but no institutional base. But BAMM's closure provoked renewed activity from senior figures in Royal Colleges to protect medical management from institutional collapse. Their activity was potentiated by the recent national policy level call (Cm 7432 2008) for better clinical leadership.

The Faculty of Medical Leadership and Management (FMLM 2017) created in 2011 was supported by the Royal College of General Practitioners (RCGP) and the Royal College of Physicians (RCP) and endorsed by the UK Academy of Medical Royal Colleges. It was not a royal college but was termed a faculty (so it had academic connotations). It launched profession building and credentialing initiatives, including a quarterly and peer-reviewed online journal (BMJ Leader) (2017), closely linked to the *British Medical Journal*. There is an annual conference of leaders in health care. They award fellowships, and also senior and founding fellowships, assessed against their own competences and standards. They offer an electronic book club and partner with other bodies to provide events, short courses and resources (but not a Masters degree). They developed evidence-based standards for clinical leaders, reflecting concern

for a research base. But many initiatives are recent and at an early stage. Membership policy is inclusive and open to medical students and non-medical professionals; yet this pluralism paradoxically may retard a strong professionalization process.

Its 2015 annual report (FMLM 2016) suggests expenditure remains at just over £1m, so is small scale. The financial model is partly based on subscriptions from clinicians (£266K) but again "other" sources of income (£659K) remain important and the text refers to short-term NHS contracts (e.g. GP coaching scheme). One question arises: will BAMM's problematic funding pattern be replicated?

Benchmarking against the Montgomery and Oliver model (2007), the UK case appears to move back from Stage 2 to Stage 1 with the closure of BAMM in 2010, but back to Stage 2 with the creation of the new faculty in 2011. There now appears to be (2017) an intent to move to Stage 3 but it is too early to assess success. There are major challenges: there is still no Royal College of Medical Management and Leadership. Clinical leaders do not have to join the FMLM. There is no prescribed or standardized curriculum for aspirant medical managers or a well-established and high volume Masters degree (although in 2017 the FLML offered some bursaries on a new Masters in Medical Leadership offered by Cass Business School in London). Budgets remain small scale with (yet again) a danger of weak membership subscriptions and overdependence on short-term NHS contract work.

Comparative Analysis and Future Research: Why Might the UK Project Be Slower?

Montgomery and Oliver (2007) suggested the US medical management field reached Stage 3 in the 1980s and Stage 4 by the late 1990s. By contrast, the UK field will struggle to reach Stage 3 by 2020 and may not do so at all. Despite limitations to the American project, it seems significantly further ahead. Nor did the American system experience the equivalent of the BAMM's sudden closure.

So what might explain this variation? Here we present some preliminary arguments. One possible reason is that the US system is more market-led, whereas the UK system is still largely in the public sector. So the greater pressures to secure competitive advantage in the US might have stimulated medical management with its particular advantage in clinically facing fields of patient safety and quality, so important for building external reputation, legitimacy and finally competitive advantage.

It is the case that there were also quasi market-style pressures on NHS Trusts from 1990 onwards. They faced strong performance pressures and targets from regulators (Rosenberg Hansen and Ferlie 2016), including in the field of patient quality and safety where visible clinical leadership is key. Nevertheless, "real" competition may still be less in the UK than in the US so, for example, the NHS-wide tariff-based pricing system means no cost-led competition. It would be interesting in future research to analyze the content of the annual reports of US and UK hospitals to explore any variation in the attention paid to clinical leadership as a theme and also in the showcasing of particular clinical leaders.

Other arguments need to be explored. Secondly and concretely, there appears to have been overdependence on volatile NHS short-term contract work and underdependence on membership subscriptions by BAMM. This problematic portfolio may be repeating itself with the new faculty. Behind this pattern may lie a failure to build a base of support amongst the clinical managerial hybrids themselves.

Thirdly, the favorable pre-history of US field formation goes back to 1950 with the initial creation of the AAMC. By contrast, UK primary-care practices have been until recently smaller scale and often run as small businesses by individual clinician owners. The American field is seen by Montgomery and Oliver (2007) as moving to Stage 2 by the late 1970s. By contrast, Griffiths (1983) was the first UK national policy push to develop clinical management, and initially in the hospital sector. So the US field displays a longer and more favorable pre-history than the UK.

Fourthly, there appears to be an earlier and more extensive development of Masters programs in clinical leadership and management in the US, perhaps linked to a more market-like higher education system that is more open to outside influence and sponsorship (e.g. from big hospital

chains). The chances of success of a "credentialist" strategy appear higher in this field with its buoyant supply side. The UK field still shows very modest investment in clinical leadership development, as yet there are relatively few programs in top-tier universities, with more reliance on in-house NHS leadership development programs.

Fifthly, and finally, in a publicly funded and nationally driven health care system (e.g. the UK's NHS), there are strong cycles of reforming and policy attention (Klein 2013). Developing clinical managerial capacity oscillated as a policy issue; it was fashionable in the late 1980s and early 1990s and again after 2008, but largely forgotten in between. Day-to-day crisis management instead often dominates attention in the politically visible health care field. Given no sustained national policy push or investment, there was a long period (say 1995–2008) when building clinical management capacity remained low priority.

This important policy and academic question of the problematic professionalization of UK medical management needs more research. The initial assessment advanced here suggests there is a slow pattern of development over a long period of time that will not easily change. Normatively, we started by asserting that the professionalization of medical management would be a positive development from a public interest point of view; but the empirical evidence (at least from the UK) suggests this process is a slow and chequered one. These findings may have relevance beyond the health care sector and pose questions for the optimal approach to the management of other professionalized or knowledge-based sectors which are of growing and strategic importance in a knowledge-based economy.

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