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Restoring expert leadership in psychiatric practice and elsewhere

Those who have worked in the public health system for over 20 years will have seen the influence of clinicians dwindle while the number of 'managers' – with the power to design and run specialist medical services – has grown, writes **Dr Cate Houen**

THE respective roles of clinicians and managers is soon to be tested in the Industrial Commission, where the South Australian Salaried Medical Officers Association (SASMOA) is representing the Flinders Medical Centre/Marion Community Team psychiatrists in challenging the failure of current governance arrangements to satisfy the terms of our Enterprise Bargaining Agreement (EBA).

Specifically, the EBA specifies that the clinical director (CD) in any medical division has both clinical and budgetary responsibility for the running of the division. In psychiatric services, these responsibilities are currently given to the executive director (ED), who sits above the CD on the governance chart, leaving the CD to 'manage' psychiatrists only. The CD reports to the ED, rather than directly to the CEO.

This means that the ED has the ultimate responsibility for decisions about staffing, facilities, and 'models of care'. The ED is employed under a contract and must meet KPIs set by the government, with top priority given to implementing government policies including cost savings.

It has become clear that, despite the rhetoric, patient care is not the primary focus for management, and that there is a misguided emphasis on trying to organise our services on business models more appropriate for car factories.

Child and Adolescent Mental Health Services (CAMHS) will be the next cab off the rank in its quest to restore sensible clinical governance to its service.

With the amalgamation of CAMHS into one service for SA, a new management structure has been proposed, again relegating psychiatrists to a role subservient to managers.

Twenty child and adolescent psychiatrists have signed a letter objecting to this managerial structure. When added to the 20 signatories to a similar letter by Southern psychiatrists, there are currently 40 psychiatrists in the public mental health system who are prepared to declare their opposition to the current governance arrangements.

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Contrary to some of the anti-medical propaganda that has become so fashionable, psychiatrists are not simply power-hungry in this quest to regain some control over the services in which they work. Psychiatrists are the most highly trained of mental health professionals, and bear ultimate responsibility for clinical decisions and their consequences. The decision-making authority that once accompanied this responsibility has been taken away.

Amanda Goodall, senior lecturer in Management at Cass Business School in London, has proposed a Theory of Expert Leadership (TEL), based on her finding that, "Successful leaders are those who have a deep understanding of the core business of their organisation. Being a capable general manager alone is not sufficient. "

She rigorously studied Formula One racing teams, research universities, hospitals in the USA, and professional basketball (NBA) teams. In each case, the best performers were led by people who were very successful and had many years of experience in their field.

Based on her findings, it is reasonable to propose that psychiatrists, preferably ▸

experienced ones, lead psychiatric services, just as surgeons run surgical units and physicians run medical units.

Managers have a place in organising the operational side of these units, in support of the clinicians, and in proper consultation with them regarding these matters. The core business of health services is patient care, and this is not what managers are trained to do, nor their core business. Most of our middle level managers once worked in clinical roles, but have not done so for some years, have been increasingly steeped in management philosophy, and are required to meet their DH-mandated KPIs in order to keep their jobs.

The Mayo Clinic, widely recognised for excellence in research and clinical care, is led by physicians. This is an excerpt from their brochure, succinctly explaining their reasons for choosing this governance:

"We stand by the philosophy that physician leadership keeps us grounded in the reason we are here — to provide the best care to every patient every day … Mayo Clinic physicians undertake rotating committee assignments where they partner with administrators to develop strategies and resolve problems because it is they who understand the practice best."

A paper by A/Prof. Neville Hicks, Department of Community Medicine, University of Adelaide, entitled *Economism, Managerialism and Health Care*, examines the impact of economic rationalism on the organisation of health services.

Hicks points out that the practice of managing health care as an economic commodity, ruled by market forces, is based on false premises: "…health is neither a commodity nor really something that can be exchanged." 'Consumers' of health care are not in a position to "assess the utility associated with all the relevant sets of final consequences", as demanded by market theory.

He also makes the point that managerialism in health services has not achieved the desired market outcomes. Despite the obsession with KPIs, quality assurance, 'best practice' and meeting budgets, these health service reforms "…have not restrained the growth in health costs, have not rationalised inefficient services and technology, have not achieved greater equality in sharing health resources and services between areas and groups of people and have not increased accountability or community involvement."

The theories of management that underpin managerialism were developed in organisations with large non-expert workforces. Health services, by contrast, according to Hicks, "consist of professional workers who require a high level of autonomy in decision-making because of the specialist, complex and indeterminate nature of their work."

There is voluminous literature on the effects of managerial reform on the Australian health care system, but at the coalface I know of few doctors, nurses or allied health staff in our service who believe that the results have been beneficial for patients or clinicians.

Amanda Goodall recognises some potential problems in the TEL model. She acknowledges that experts may be too self-focused, unable to empathise with others, and overly confident in their abilities. Good leaders, she argues, are those who "show humility (a capability to listen to others) instead of hubris (expressed as over-confidence)."

Integrity and empathy are other qualities cited as important for good leadership. I would argue that these qualities are equally important for all leaders and managers, regardless of their expertise in other areas.

If psychiatrists are to reclaim expert leadership of psychiatric services, we will need to learn some management and leadership skills, and remain involved in clinical work, to avoid losing that essential of expert leadership – "a deep understanding of the core business" of psychiatric practice.

We should not throw the baby out with the bath water – we should recognise the value of managers in supporting the operations of our services, and work in partnership with each respecting the skills of the other.

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