THE CHANGING EXPERIENCE OF WORK OF CONSULTANTS IN NHS SCOTLAND

EXECUTIVE SUMMARY

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Background and Rationale for the Study

1. The Scottish consultants committee (SCC) of the British Medical Association sought to understand the nature of the changing experience of work among consultants in NHS Scotland following anecdotal reports from members concerning a loss of autonomy and authority over recent years.   The SCC also sought to comprehend the range of views held by consultants on their changing experience of work, their nature, antecedents and consequences, and the extent to which views varied among consultants employed in the NHS in Scotland.

2. To address this question we conducted an extensive literature review into explanations of loss of autonomy and control among professions in healthcare, and on doctors' changing experience of work. This review led us to develop a framework that linked explanations of potential loss of autonomy and control among consultants – so-called deprofessionalization - to key outcomes: (a) their trust in managers and Boards, (b) the nature of their engagement with their immediate work, their clinical teams, their employers and the NHS in Scotland, (c) their ability to express their ideas and feelings, and participate in decision-making – otherwise known as 'voice', and (d) their perceptions and accounts of the effectiveness of the healthcare system in Scotland.

Methods

3. We undertook a mixed-methods approach to data collection. The first stage involved in-depth, semi-structured interviews with 68 consultants in Scotland during the period May to September 2014. The questions were informed by our literature review but we were also open to directions that interviewees wished to take us in since our objective was help them reflect on, and articulate, their experiences since first appointment as a consultant.

4. Interviewees were selected to ensure maximum variation among consultants in all boards in Scotland, and in all types of hospitals, specialties, contract and age ranges. The number of interviews conducted was also guided by 'theoretical saturation', which applies when interviewers feel they are learning less and less from additional interviews.

5. Initially, interviewees were selected from a BMA database of consultants in different boards in Scotland. This group accounted for slightly more than half of the final sample. These interviewees helped enlist colleagues in their boards who were willing to be interviewed, especially is specialties and career stages that were underrepresented in the initial sample. Finally, to mitigate sampling bias as best as we could, we sought interviewees who were neither initial volunteers nor volunteers secured through BMA contacts to assess whether their views were different from earlier interviewees.

6. Interviews were transcribed verbatim, which produced more than 1500 pages of text. Using a coding frame, this text was analysed for common themes and variations in views on these themes, which were subsequently used to design a survey for a follow up survey. This survey aimed to understand the extent to which views were held to build on the in-depth and nuanced views provided by the interviews

7. The survey consisted of 53 questions, divided into six sections on themes generated by the literature and from issues raised by the interviews. Some of these sections drew on pre-validated items used to measure trust, voice, and different types of engagement; others were designed by us to assess issues raised by the interviews such as perceptions of clinical and medical management, rationales underlying decision-making, etc. These were followed by six questions on the demographic profile of the respondents. The survey was piloted on a group of consultants, who provided extremely useful feedback that led to a revision of some of the language and categorization of consultants used in the survey.

8. The revised survey was distributed online to 3740 consultants using the BMA's database, via an email invitation from the BMA and the research team. Potential respondents were invited to use a web link to access the survey. A reasonably good response rate for online surveys of 28.6% was achieved, with 1058 consultants completing the questionnaire.

9. An 'any further comments' section was provided in the survey, which produced 430, frequently lengthy and reflective, free text responses. These data were also subject to analysis and have contributed substantially to the overall picture from our mixed method data collection.

Key results

10. The interview and survey data suggested that consultants perceived significant change in the dominant rationales governing decision-making in their work situations and in the NHS generally. A business-related rationale was seen to dominate decision-making rather than the rationale of medical professionalism, which consultants tended to equate with good patient care. While the NHS has always had to accommodate potentially conflicting rationales, consultants felt that the balance had 'tipped too far' towards business and financial decisions dominating how work was organized and evaluated, and that such a trend was inconsistent with effective and efficient patient care. During the interviews it was also evident that many consultants linked the business and finance rationale to a political rationale. This political rationale was seen to arise from (a) politicians' promises to the general public to meet increasing demands from an aging population for a better quality of healthcare without being able to fully resource such promises, or (b) from direct political interventions in how and where healthcare funds were spent. However, it was also evident that those consultants who had previous or current experience of medical management were more accepting of the conflicting nature of healthcare rationales and the needs to balance them in decision-making.

11. This clash between business-related and political rationales on the one hand and medical professionalism on the other, appeared to be the underlying cause of relatively widespread feelings and expressions of deprofessionalization among our interviewees and survey respondents. Deprofessionalization was expressed in the following ways:

i) Consultants saw increased patient demands as challenging and in some cases misplaced. They attributed such views to a political rationale, to the role of the media in promoting 'bad news' stories about the NHS, and to enhanced access to self-diagnosis through the Internet in creating a 'want it now' culture. Patient demands and expectations, however, were unequally distributed among the Scottish population. In under-privileged sections of Scottish society, many patients and their families were still more unlikely to challenge medical opinion or practice, which was not the case with the affluent middle-class, who often placed greater demands on consultants. Nevertheless such challenges did not cause consultants to feel that their status with patients had been diminished; indeed interview accounts and the survey data suggested that consultants felt they still enjoyed high levels of respect and trust in their judgement, and perceptions of integrity, despite the constant, as they saw it, media attention on failings in the healthcare system. Moreover, many consultants welcomed more informed patients and challenge to the previous image of doctors as omnipotent and distant.

ii) The levels of negative comment and graphic accounts of how increasing bureaucracy and non-clinical 'managerialism'[5] had shaped changes in their work experience were among the most marked points in our findings. These feelings were especially strong in relation to the dysfunctional consequences associated with the reliance on a performance management approach to reform in NHS Scotland, including: (a) waiting times and targets, (b) the variable implementation of the 2004 consultant contract (c) multiple layers of needless paperwork, and (d) the increasing power of non-clinical managers, who were seen to exercise a strong degree of control over the consultants' working lives. Consultants tended to see the increasing power of non-clinical managers as an especially worrying development associated with performance management and inconsistent with improving patient care. Although many consultants had sympathy for non-clinical managers' having to do a difficult job in difficult circumstances, many spoke of the imbalance of power having gone too far in the direction of detached managerialism, and a need to redress this imbalance. However, not all consultants were of this view: younger consultants and, particularly, consultants with experience of medical management tended to express less negative views of increasing bureaucracy and managerialism.

iii) Increased regulation introduced by elite medical bodies such as the GMC was also seen in negative terms.   Attempts to introduce processes such as revalidation and appraisal were viewed as unhelpful initiatives, which neither improved system effectiveness nor aided the development of early and mid-

[5] A belief in the values and practices of professional management as a solution to organizational problems, which has become a marked feature of the NHS over the past three decades

career consultants. Although appraisal was typically described as good in theory, the practice of 'box-ticking' had caused to the system to lack validity among appraisers and appraisees, and to be deemed a 'waste of time and money'. The issue of who was selected to fulfil the role of appraiser was frequently raised, especially in relation to the appraisers who were thought to align with a business or financial rationale.

iv) The introduction of clinical leadership and medical management drew mixed views. On the one hand, most consultants wished to see more consultants in such roles, but, on the other, the experience of appointing consultants to these positions has not led to a majority of consultants' experiencing major improvements in the system nor to perceptions that medical judgements were being taken into account at Board management level. Indeed, in line with much of the literature on clinical leadership, consultants without experience of medical management tended to see colleagues who had taken up leadership positions as having become incorporated into the bureaucracy and a managerial agenda. However, we found that consultants with experience of medical management and clinical leadership tended to hold a more positive view of medical managers' capabilities to generate change. Nevertheless, medical managers acknowledged that the part-time nature of many clinical management roles limited their impact, and sometimes caused clinical managers high levels of stress resulting from role conflict.

v) There was limited evidence of the routinization of work. Consultants appeared to find their jobs appropriately challenging, with many reporting increased job challenge during their clinical careers as consultants. However, interview accounts and the survey data stressed that their medical judgements were becoming routinized, with new bureaucratic procedures and the control exercised by non-clinical management limiting their clinical freedom to the detriment of patient care.

vi) There was some evidence that consultants saw the introduction of unnecessary dress codes, changes to their quality of office accommodation and a lack of meeting spaces as a symbolic challenge to their status, and as inconsistent with effective working and with the traditional 'communities of practice' that had previously characterized consultants' working experience.

vii) There was also evidence that some consultants felt increasingly devalued because managerial values and practices, and associated bureaucratic control, had challenged their status as the most highly qualified professionals in the healthcare system. Instead, some reflected that they were being seen as members of a healthcare 'workforce', increasingly subject to a wage-work bargain like any other healthcare worker. One consequence of these feelings of possible 'proletarianization'[6] was survey evidence, especially from earlier career consultants, showing a greater willingness to take collective action in pursuit of grievances.

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[6] Perceptions of proletarianization relate to the de-skilling and routinization of professional work and to perceptions of professional status being downgraded.

12. There was strong evidence of a lack of trust in managers in general and trust in senior management. Consultants responded to performance management, bureaucratic control and managerialism by expressing a marked lack of trust in the competence and integrity of non-clinical managers and, to a lesser extent, medical managers. Not surprisingly, consultants with experience of medical management were more inclined to trust the system, and to have a more positive view of doctors becoming involved in clinical leadership and medical management as solutions to improving the system through consultation and communication.

13. However, contrary to what might have been expected in organizations characterized by low trust dynamics, both the interviews and survey data on engagement showed that consultants were highly engaged with their jobs, with their clinical colleagues and with the values of the NHS. Engagement with the values of the NHS in general was particularly high, with some consultants pointing to the superiority of the NHS in Scotland as a major influence on their engagement. However, and consistent with the professional orientations to work of consultants and negative views of bureaucracy and managerialism, engagement with their organizations was only moderate to low.

14. One of the strongest findings was that consultants felt a marked lack of opportunity to express their ideas and feelings, and to participate in decision-making over issues that directly affected their working lives. The survey results show these aspects of voice[7] to be the most negative aspects of consultants' experience of work. The interview data indicated that some consultants saw this lack of opportunity to express voice as a deliberate strategy on behalf of non-clinical managers, intended to disempower consultants or avoid confrontation over difficult decisions. However, there was some variation among different groups of consultants in how they responded to the survey. For example, consultants with experience of medical management recorded significantly better perceptions of communications.

15. Despite these negative perceptions and accounts of their changing work experience, the majority of consultants regarded the NHS in a very positive light and identified strongly with the values of the NHS, which was particularly evident in the survey data. Although some consultants during the interviews pointed to other systems of healthcare as being superior in certain aspects of healthcare delivery, most of the interviews showed that consultants regarded the NHS as among the most effective systems in the world. However, it was also generally felt to be creaking under the strain of having to deal with year-on-year greater 'demand inflation' unmet by proportionate increases in resources. These pressures were often seen to arise from politicians over-promising to deliver world-class healthcare to an expectant general public, which were reinforced by local and national media seeking to increase circulation and generate political capital from 'bad news' stories about the NHS, e.g. on waiting times and hospital failures. As a consequence, a widely shared view held by many interviewees was a sense of or frustration, sometimes bordering on hopelessness, over how to make the system more effective. Few

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[7] Voice has been defined as the right to express opinions and have meaningful input into work-related decision-making.

interviewees had a strong sense of control over their working lives or were able to offer solutions to how to 'fix' the system, which led in some cases to reports of increased stress and/or decisions to leave their employers or to retire early. While consultants wanted to see more doctors in management, many fewer had faith that consultants in management roles were capable of changing institutions outside of their control. Instead, most consultants pinned their faith on improving the opportunities for greater consultant voice, though without much faith that greater voice and participation in decision-making would or could change the now established political and economic institutions of healthcare in NHS Scotland.

Conclusion

16. Overall, our research reveals significant concerns among consultants over the impact of managerialism, bureaucratic, financial and political controls on their professional autonomy and freedom, and their evaluations of the sustainability of the healthcare system. As researchers, we could not be other than impressed with the levels of engagement that interviewees expressed about their jobs and colleagues. At the same time, however, we detected a strong note of pessimism, even fatalism, over how the healthcare system could be improved for the benefit of all stakeholders, without substantial improvements in resources allocated to the NHS in Scotland. These feelings, if left unaddressed, could have major consequences for patient care and the overall sustainability of NHS Scotland.