The Role of the Professional Representative in the Management of the National Health Service

Abstract

The thesis is about the role of professional representatives in the management of a large organisation - the National Health Service. Members of professions frequently work in organisations the leadership of which must reconcile professional and administrative occupational ideologies if its ability to determine policy and ensure its implementation is not to be frustrated. Co-optation of professional representatives onto management executives is one means of attempting to reconcile such ideological tensions. The success of such co-optation is dependent upon the structure of the professions and the representative systems devised.

Since its inception, the National Health Service has encouraged participation by clinicians in advisory, administrative and managerial capacities. Until 1974 such participation was largely by hospital consultants rather than GPs. One of the chief objectives of the 1974 reorganisation of the NHS was to integrate the three branches of the service and so GPs were made full members of the district management team. The position of GPs within the production and distribution of services was seen to be central and therefore the success of integration depended upon the representative process.

The research reported in this thesis examines the role of the GP team member. Five national surveys were conducted of GP team members, District/Area Medical Committee Secretaries, District/Area Administrators, GPs, and Local Medical Committee Secretaries. Survey findings are used with interview data to examine a number of hypotheses about the representative process, co-optation in a large organisation, and co-optation and the 1974 reorganisation of the NHS.

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CHAPTER ONE

THE COMPLEX ORGANISATION

1.1 Introduction

To understand the role of professional representation within a complex organisation requires first an analysis of the organisation itself. The term complex organisation is used to denote an organisation which employs groups of workers who have different goals, ideologies and patterns of work.[1] Two such groups of workers are those whose work is organised according to professional criteria and those who accept administrative criteria. A complex organisation may have several different groups of professional workers as well as groups which show some professional characteristics as in Etzioni's concept of the semi-professions (Etzioni, 1969). These groups of workers are dependent upon each other, at least to the extent that they share an interest in the continued existence of the organisation, although the extent of this interest may vary between occupational groups and even within occupational groups.

Professional and Administrative groups within an organisation have radically different principles concerning the ordering of work and the system of relationships which make up the organisation. These principles are examined in sections 1.2 and 1.3 of this chapter which look at the consequences of the difference in work orientation and ordering for the organisation. The problems encountered fall into the functional category of systems maintenance (Parsons, 1953) and can be identified as policy determination and implementation.[2] These two activities are vital to the survival of the organisation although they may occur in a number of different ways at different levels in the organisation. This theme is developed in sections 1.4 and 1.5.

The strategy of co-optation (Selznick, 1966, p.13-16) has been suggested as a solution to the organisational dilemma where policy determination and implementation are threatened by the existence of professional and administrative forms of work ordering within the organisation.[3] Representatives of the relevant groups are given membership of management executives within the organisation and thereby have the opportunity to contribute to policy determination. This membership of the corporate executive enables the group to participate, to some degree, in the policy-making process although it is not clear that this will result in the implementation of such policies .

1.2 Professional Work

Writings on professionalism fail to distinguish clearly between members' concepts and sociological theory with the result that much of the discussion oversimplifies the concept, or is simply confused. Dingwall makes the point forcibly,

> It is my contention that this confusion results from sociologists' treatment of lay social theories as impoverished sociological theorizing rather than as phenomena to be studied in their own terms ...
>
> ... we should therefore abandon any claim to legislate a correct use of the term 'profession' but treat it as a members' concept and seek to describe its practical usage in everyday life.
>
> (Dingwall, 1976, p.91).

This warning is important since the naive treatment of profession, as a concept to be compared with non-profession, hides the complexity of the subject and also the fact that the concept of profession may be used by occupational groups as a strategy to control the activity of work and a means to achieving an occupational and social status.[4] For this reason the analysis does not commence with a definition of

professionalism since the purpose of such a definition, the clear distinction of one phenomenon from another, implies a bounded phenomenon which is not the case in the discussion of professions.

Denzin has suggested that sociological analysis and research should employ a "multiple triangulation approach" as a means of avoiding the shortcomings of any single researcher, theory, methodology, or set of data (Denzin, 1970, chapter 12).[5] Following this suggestion the discussion of professional work attempts to employ several theoretical approaches which are based upon evidence collected using different methodologies. The aim is to complement the inadequacies of various theoretical approaches and so answer a wider range of questions than is possible using single methodologies.

Reviewing sociological writings on the professions, Ritzer has distinguished between three sociological approaches which he terms structural, processual and power approaches (Ritzer, 1975, p.630). The "structural" approach attempts to answer the question: what are the characteristics which distinguish professional occupations from other occupations? The "processual" approach deals with the way in which occupational groups and individuals obtain professional status and maintain or extend it. The power approach concentrates on the effects of professional status and power on the ordering of work and the relationships which arise from work.

Ritzer's characterisation of his first approach as structuralist stretches the conventional meaning of structuralist analysis since it is chiefly concerned with distinguishing between occupations in a taxonomical sense without accounting for the structural determinants which affect the status and activity of occupational groups .[6]

Perhaps the earliest example of Ritzer's "structuralist" category is Flexner's attempt to decide whether social work constituted a profession (Flexner, 1915). He compared a number of occupations commonly accepted as professions and picked out common traits. He then used these traits to see if social work could be labelled a profession. He concluded that it did not satisfy sufficient traits and therefore failed the test although he commended it upon its "professional spirit". Clearly the value of such analysis is limited since it is based on a comparative method and relies heavily on the interpretation of the investigator. More recent examples of this approach include studies by Goode (1957), Greenwood (1957), Bennion (1969), and Millerson (1964). Millerson's approach is distinctive since it reviewed a wide range of trait analyses and discovered 23 different attributes. This finding of wide variation between different analysts tends to question the validity of the method and the "theories" that have been put forward.

A development of the trait approach is found in the work of Hickson and Thomas who attempted to operationalise Millerson's 23 traits using a Guttman cumulative scale but without much success since the scale could not distinguish between different occupations and professions (Hickson and Thomas, 1969). More importantly, this attempt to operationalise the "traits" observed in "professions" does not assist in answering questions about occupational development or the behaviour of occupational groups and their members which are generally recognised as professions.

The explanations which these trait theorists put forward are not structuralist in conventional terms (see Giddens, 1979, chapter 1; Wallace, 1969, pages 24-34). Their work describes many features of professional occupations and the way in which professional work is

typically organised. There is a normative element in the explanation since it is often tacitly assumed that most occupations aspire for the ideal status which professional recognition brings. There are no criteria for distinguishing occupations which are likely to become professional from other "non-professional" occupations.

This cursory treatment of the trait analysts should not hide the problems which are highlighted by their failures of explanation. For instance, the assumption that it is self-evident which occupations are professions is hard to sustain when the existence of marginal groups or semi-professions is recognised (Etzioni, 1969). Furthermore the concept of the "unitary profession" has been questioned in our examination of trait analyses since there is a wide range of variation between professions.

Millerson has argued that in some cases the analysis itself is a form of special pleading on behalf of the occupational group concerned and therefore indicates an important normative aspect to the process of professionalisation which we shall examine below (Millerson, 1964, p.3). In Bennion's study the profession attains not simply an empirical status but also an ideal, normative status which benefits society (Bennion,1969).[7] Johnson has explained this phenomena as the acceptance by the analyst of professional codes,

> Unquestioningly to accept the professional code as a sociological law is, to say the least, premature as it is to assume that the application of the codes is uniform in its beneficial consequences for different sections of the community.
>
> (Johnson, 1972, page 25).

Caplow and Wilensky identified five stages through which occupational groups pass in the process of acquiring professional status (Caplow and

Wilensky, 1964). This "natural history of professionalisation" starts with the establishment of full-time practice, followed by the creation of a training school, the formation of a professional association, the attainment of a legally recognised monopoly and finally, the production of a code of ethics for members. This analysis suffers from its generalised nature since occupations may follow different orders in their pursuit of professional status while some follow each step and fail to obtain recognition.

Elsewhere Ritzer has spoken of a professional, non-professional continuum which portrays professionalism as a continuous, single variable (Ritzer, 1973, page 61). Such a view of professionalism recognises but cannot account for the variations between occupational groups which are regarded as professions, or within "professional" occupations except to say that one is more or less professional than another.

The next group of theories pose the question, "what do professions and their members characteristically do?" The focus is upon the activity and organisation of work rather than upon classification. Closely allied to this approach is the question, "How do occupational groups achieve and maintain professional status?" Caplow and Wilensky failed to answer this question on the test of empirical evidence by seeking a unitary process through which each occupation must pass (Caplow and Wilensky, 1964). Bucher and Stelling identified two forms of professional activity namely "role creation" and "negotiation" (Bucher and Stelling, 1969) . Their study concerned the activity of medical staff within a teaching institution and focussed, in the first instance, on the individual professional who obtains professional status through interaction,

> Observing professionals and aspiring professions in various organizational contexts reinforces the viewpoint that being 'professional' is an honorific status which arises out of interaction among specific audiences.
>
> (Bucher and Stelling, 1969, p.4).

Thus the individual professional makes claims for professional status amongst specific audiences and the reward is autonomy in a particular area of work. Claims may be challenged or rejected and so autonomy needs to be maintained and defended. The autonomy of the individual professional and the intra-professional group is limited through the process of competition. As in the economic sphere, perfect competition is seldom the case and monopolies may exist and be firmly defended.

This analysis is also applied to the aspiring occupation which may make claims for autonomy in a particular area of work. In the case of the medical profession the recognition of autonomy came in the 1858 Medical Act which established the General Medical Council and effectively controlled entry to the profession through its control of the training system. This did not imply complete autonomy over the "terms" and "content" of work but established a legal monopoly over the right to claim medical status and treat patients [8]. This autonomy may be challenged, usually at the margins of medicine by those who support social rather than medical models of care [9].

These analyses of professionalism, which focus upon the process of obtaining professional status, are complemented by Ritzer's third category of theorists who concentrate on the question of power (Ritzer, 1975). Freidson argues that autonomy is the central feature of professional work (Freidson, 1970, p.134). He follows Bucher and Stelling in suggesting that claims are made about professional work, and these help to obtain and maintain professional status,

> ... I would suggest that notions of dedication to service and of craftsmanship are more usefully treated as elements of an ideology than as empirical characteristics of individual and collective professional behaviour. Taken as ideology they have empirical status as claims about their members made by

> occupations attempting to gain and maintain professional monopoly and dominance.
>
> (Freidson, 1977, p.32).

The function of ideology in obtaining and maintaining professional status and control over the organisation of work forms an important theme which is discussed in detail in section 1.4. Since autonomy is about the organisation of work it is important to be clear about the conceptual armoury employed. The first distinction is between the "terms" and the "content" of work (Freidson, 1970, part IV). The terms of work refers to the way in which work is organised, namely the relationship between the occupational group and the employer, or alternatively the form of practice orientation adopted (such as independent practice). The content of work applies to the activities of work which make up the job. Autonomy is likely to be restricted to the content of work leaving the terms of work as a matter for negotiation or competition. Freidson makes this point in the book Professional Dominance,

> Clearly the economic and political autonomy of the medical profession varies from country to country. What seems invarient, however, is its technological or scientific autonomy, for everywhere the profession seems to be left fairly free to develop its special area of knowledge and to determine what are scientifically acceptable practices.
>
> (Freidson, 1970, p.83).

Perhaps it should also be noted that western medicine is not constrained by national boundaries and therefore technological and scientifically accepted practices develop across nations. An absolute distinction cannot be made between the terms and the content of work since the question of acceptable practices is not insulated from the context in which such practices develop[10]. The distinction is nonetheless a helpful one.

Pettigrew identifies four types of activities which an occupation or profession must undertake in obtaining and maintaining autonomy over the content of work (Pettigrew, 1973, p.100). It must define the boundaries of the field of work with which it is concerned, its major body or knowledge and associated methods. Secondly, the occupation needs to define a mission which it pursues and a value-system which maintains and justifies it. Thirdly, it must be clear about the activities which are proper to its field. Finally, it needs to be clear about the relationships which obtain between members of the field and persons in other fields or occupations. The occupational ideology will cover each of these aspects of the content of work and the social relationships which arise within and from work.

Gyarmati has suggested that autonomy must be associated with a legally enforcible monopoly for an occupation to constitute a profession (Gyarmati, 1975, p.629). He insists that the monopoly must be enforcible in law to prevent encroachment from other occupational groups or practitioners. There are other ways in which a monopoly may be enforced, which have the effect of preventing encroachments such as manipulating the cost of services provided within the market to prevent the outsider being able to find a clientale or demand for his services. The legal recognition may, or may not, offer advantages to the consumer or client in the regulation of practitioners and exclusion of unqualified providers. It does enable the profession to enforce their monopoly, control entrance to the occupation and control the content of work.

Freidson's discussion of professional autonomy employs concepts drawn from the work of Gibbs and Martin (Gibbs and Martin, 1962) to

explain the division of labour (Freidson,1977). The "degree" of the division of labour refers to the extent of occupational differentiation and the "basis" concerns the criteria by which a person's position in the division of labour is determined. He emphasises the importance of such bases giving examples such as "the free-market economy", "the feudal society", and the "rational-legal bureaucracy". These bases constitute an ideology; a set of consistent principles concerning the organisation of work and the relationships which arise from that organisation. Such ideologies do not necessarily constitute accurate descriptions of the way in which work is actually organised.

The concept of autonomy can be examined at three levels in the discussion of professions: at the level of the profession; at the intra-professional group level; and at the level of the individual "professional". The achievement of legal monopoly is one means by which autonomy is obtained and the individual practitioner obtains professional status through the licensing process. The individual also obtains limited autonomy through specific interactions (Bucher and Stelling, 1969, p.4). The intra-professional group share either a similar content of work (or specialism), or a particular practice orientation on which their autonomy is based.[11] Each of these bases of autonomy involve some degree of control over the content of work. Claims for autonomy may be challenged from within or without the profession or the intra-professional group, or indeed by other members of the profession[12].

These three sorts of autonomy are upheld by important ideas widely accepted within and outside the profession. For the individual doctor the concept of the doctor-patient relationship underpins the ideology of clinical work and the relationships which stem from work. The doctor

cannot be overruled in the individual clinical decision, at least in principle. Specialist accreditation, both for hospital doctors and GPs, gives the doctor the right to treat a particular range of cases and also confers membership of a body of doctors who share a particular practice orientation. Autonomy is limited to the particular specialism and must also take account of resource availability. Specialist groups may challenge the autonomy of another specialism often by offering novel treatments . An instance of this is the case of geriatric medicine which competes with general medicine for patients and frequently also for beds - which constitute the currency of the hospital specialist. Claims for dominance may also be made from other professions and occupations particularly at the margins of medical practice. It is not, for instance, infrequently argued that a social model is a more appropriate way of helping the mentally handicapped than a medical model. It follows from this argument that social service provision is more appropriate than medical or hospital provision for meeting their needs[13].

Freidson argues that autonomy is sustained by dominance in the relevant field of practice (Freidson, 1970, p.136). This concept parallels Bucher & Stelling's description of "having ones claims accepted" identified at the individual level (Bucher and Stelling, 1969 p.4). Dominance refers to the content of work and so it is reasonable for Freidson to argue,

> ... when an occupation has become fully professionalised, even if its work characteristically goes on in an organisation, management can control the resources connected with work, but cannot control most of what the workers do or how they do it.
>
> (Freidson, 1973, pp.21-22).

Similarly the intra-professional group may have dominance over a particular area of work enabling them to successfully resist challenges from other groups. The ability of management to control the resources available to workers, i.e. the terms of work, does enable them to influence the content of work. There is evidence[14] that this influence is often negative since it is easier to constrict the flow of resources than to ensure that professional workers use resources in particular ways. Thus the professional worker is seldom accountable for individual decisions or the management of single cases but he may have to follow agreed policies in his work or be subject to sanctions imposed by management.

1.3 Administrative Work

The term administration is used to refer to a series of principles upon which work may be ordered in a complex organisation. The concept of bureaucracy has been avoided because it carries a series of negative connotations and implies a monocratic organisation[15]. In the complex organisation the administrative principle may vie with professional, democratic or political codes upon which work is organised. Writers such as Green have envisaged dualistic organisations in which professional and administrative principles conflict as the basis for the organisation of work (Green, 1975; Hall,1968; Engel, 1968). This tendency to polarize the tension between professional and administrative ideologies as bases for the organisation of work does not fit with the foregoing discussion of professional work and the degree of fragmentation and intra-professional group development described. Other writers such as Engel have noted a wide range of "bureaucratic" organisations and she suggests distinguishing between them on the basis of degree: giving non-bureaucratic, moderately bureaucratic, and highly bureaucratic as

points on a continuum (Engel, 1968, p.34). This does imply a one-dimensional view of the concept of bureaucracy.[16]

The Administrative component of an organisation can (also) be examined using the concepts of structure, process and power. There has been an emphasis on the structural components of an organisation, largely because they are the most apparent elements to the observer. The discussion of bureaucracy has been central to discussion of organisation and Albrow rightly points to the wide range of definitions employed (Albrow, 1970, chapter 1). Weber placed his concept of bureaucracy in the middle of an enormous historical and social process - namely the rationalisation of the western world (Albrow, 1970, p.43). He argued that bureaucracy depended upon,

> the imperative co-ordination of work on the basis of the legitimate authority or office.
>
> (Henderson & Parsons, 1947, p.339).

The source of authority is located in the process by which the system of offices is legitimated. In other words the system of offices is part of an accepted ideology and orders are legitimated through the use of the ideology and its key ideas. The administrative principle rests on a series of ecumenic ideas through which systems of rewards or sanctions can be implemented.[17] The historical nature of Weber's analysis points to the need for continued legitimation of authority (see Gouldner, 1955). There are also informal patterns of organisation within administrative organisations which underpin the formal order and frequently arise to deal with dysfunctional elements. (Selznick, 1966, pp.251-2).

Selznick has argued that the most important problem for an organisation is that of delegation; the process by which each office is assigned duties and the appropriate resources (Selznick, 1961, p.19).

Administrative organisations have usually espoused rational or rational-legal systems of values and roles which set out the most efficient means of achieving stated objectives through a clearly articulated system of logical roles. The organisation must be able to co-ordinate the work of office holders who have personal views about how work should be done and often approach aspects of work with "hidden agendas" (Bradford, 1978). Gouldner has identified two means by which an organisation may attempt to ensure compliance and suggests that there are two sorts of bureaucracy; "punishment-centred" and "representative-bureaucracies" (Gouldner, 1954, pp.187-214). In the former, members of an organisation comply with orders because they fear sanctions may be applied if they do not comply. In the latter they only obey rules with which they agree on moral or rational grounds. Many organisations will require both modes of compliance of legitimation employing punishment as a last resort.

Weber identified three bases of authority within an organisation which he termed charismatic, traditional and rational-legal (Gerth and Mills, 1946, p.295f; Henderson and Parsons, 1947, p.324f). The bureaucracies which he studied were characterised as rational-legal. Members accepted the roles since they were technically justified and often backed up by legal prescriptions. While Weber's claims for bureaucracy have been widely challenged pointing to the problem of "red tape" and the difficulty in coping with innovation (see Albrow, 1970, p.58; Burns and Stalker, 1960), he did point to important characteristics such as,

> precision, speed, unambiguity, knowledge of files, continuity, discretion, unity, strict subordination, reduction of friction and material and personal costs.
>
> (Gerth and Mills, 1946, p.214).

The most important criticism of this view of bureaucracy or administrative organisations, is that it does not provide an accurate

description of how such organisations actually work. Merton speaks of the bureaucratic personality and its dysfunctional characteristics (Merton, 1968, chapter 8). Parsons has questioned whether there is likely to be sufficient expertise in the upper echelons of an organisation to enable it to function in the way Weber envisaged (Henderson & Parsons, 1947, pp.58-60). It may also be suggested that if such expertise does exist there may be tendencies towards professionalism within the organisation which impose different patterns of relationships and loyalties.

The efficiency of administrative organisations has been related to the stability of the task which it has to fulfil (Burns and Stalker, 1960). Dealing with innovation may prove to be a particular problem since the organisation is designed with a specific range of tasks in mind and assuming a particular technology. Additionally, if demand for the product of an organisation is fluctuating, the administrative organisation may not be the most efficient way of meeting such demand. It follows that administrative organisations have clear limitations and their usefulness depends upon: the scale of the operation; the nature of the technology; the stability of demand; the requirements of the environment; and the need for equity in dealing with clients.

The ability of the leadership to make appropriate policy decisions must be questioned in a complex organisation. The limits of authority and responsibility of each office must be carefully and clearly defined. Selznick points to five elements of system maintenance which an organisation has to ensure. Firstly, the organisation has to defend itself from social forces in its environment. In many complex organisations political forces will operate which threaten or constrain the technical rationality of the organisation. Secondly, the organisation must ensure

that lines of authority and communication remain stable. Thirdly, informal relationships within the organisation must also remain stable. Fourthly, continuity of policy and leadership must be sustained and finally, homogeneity of outlook amongst members concerning the objectives of the organisation must be maintained (Selznick, 1966, p.252).

Serious failure in any of these aspects threatens the efficiency of the organisation and ultimately its existence. Threats from outside and inside the organisation must be recognised and dealt with appropriately. This thesis restricts itself to threats from within the organisation although they cannot be completely separated from external influences. The whole organisation may be subject to social, political or economic pressures which make system-maintenance more difficult. Political decisions may frustrate both the aspirations of the leadership and members of the organisation as well as leading to instability in patterns of demand.

1.4 The Ideological Components of Work

Professional and Administrative principles of work both require a theory of ideology to explain their significance. Sumner has identified four main elements of this concept (Sumner, 1979, p.6). Ideologies are elements of consciousness; they originate in social practice; and they are widespread throughout a society. This analysis is descriptive and does not refer to the purposes or effects of ideologies. Occupational ideologies concern the four sorts of activities identified by Pettigrew and referred to on page 9. They define the appropriate field of work for the occupation and its members; they outline the purpose and value system of the group; they define the activities which are suitable for members; and they indicate the appropriate relationship between members of the group and other occupational groups and individuals (Pettigrew, 1973, p.100).

Both administrative and professional ideologies correspond to Sumner's conceptualisation since they are recognised by members of the occupational groups and the wider society. They concern the terms and content of work and to some extent the social relations of individuals in the wider society. For instance, the appropriate relationship between client and professional is an important element of professional ideologies and in medicine is seen in the sick role (Parsons, 1951, p.439f)[18]. There is also evidence that professionals maintain a particular version of reality in potentially stressful situations which enforces the ideology (see Emerson, 1970).

What, then, are the functions of occupational ideologies for members of the occupational group, for other occupational groups, and for society? On page 7 it was argued that professions, and the groups within them, make claims to a status which implies a special position within the division of labour and autonomy over the content, but not the terms, of work. The administrative principle acts to legitimise the exercise of authority and the delegation of work within and organisation and functions to order relationships within and with outsiders. Mannheim identified two sorts of ideology which he labelled 'ideology' and 'utopia' (Mannheim, 1946, p.36). Ideology was used to refer to the legitimation of existing social relations, while utopia was the system of beliefs and values corresponding to a non-existent but desirable set of social relationships. At its simplest, ideology concerned maintaining social relationships and utopia concerned creating new social relationships. Occupational ideologies concern both aspects since existing relationships need to be monitored and developed into new forms. Thus occupations make claims for professional status which involves modifying existing patterns of work and relationships in order to create new relationships which more closely relate to aspirations.

In his discussion of professional dominance, Freidson ideologically connects the terms of work with the content of work (Freidson, 1970, page 18)[19]. It is scientific dominance which justifies autonomy over the content of work and its associated relationships. It is the exclusive possession of this knowledge which is used to justify a position within Hughes' moral division of labour (Hughes, 1958, p.34).

The ideology which underpins the administrative principle is concerned chiefly with the patterns of relationships between offices in the organisation. The ideology rests upon the rational nature of rules spelling out the appropriate relationship between offices and procedures covering the process of work. Key ideas such as equity, efficiency and impartiality characterise such ideologies which are, not descriptions of how the organisation functions but rather, act to legitimise the authority of office-holders and the orders which they give.

Occupational ideologies do not solve the differences of interest within a profession arising from the competing interests of intra-professional groups. They may, however, suggest the means by which such disputes are dealt with. For instance, differentiation within the medical profession may cause problems concerning the fields of work and appropriate relationships between GPs, general surgeons, cardiologists, and surgeons with an interest in cardiology. There are key ideas about the responsibility of doctors for patients and the transfer of that responsibility, albeit temporarily, between doctors which apply to such problems. Additionally, autonomy over particular areas of work is related to the recognition of expertise in that particular field which may also relate to the seniority of the doctors concerned. This medical ideology sets important 'rules' within which intra-professional relationships take place and indicates certain important ideas in questions of dispute.

Dibble has argued that ideologies are composed of norms, or value-judgements which lie on a continuum between parochial and ecumenic ideas (Dibble, 1962, pp.229-31). Parochial ideas are shared between a narrow section of society and have limited application while ecumenic ideas are widely shared and have a wide scope for application. Parochial and ecumenic ideas also vary in the degree of sophistication with extremely sophisticated norms which compose some ideologies. For instance much of legal practice rests upon norms such as justice which underpin the forms of relationships practitioners have with clients and others. Thus part of an ideology may be seen in formal codes of ethics which show the appropriate forms of behaviour for members. Systems of relationships based upon parochial ideas were shown to affect the organisation of work in small work groups in the Hawthorne Studies and also in more recent studies of patterns of informal organisation (Mayo, 1933, 1949).[20]

Dibble argues that the success of an ideology as an aid to occupational development depends upon the extent to which it is based upon ecumenic ideas; the degree to which it deals with the central life concerns of the client or society; the existence of alternative sources of help; and the extent to which the clientele is heteronomous (Dibble, 1962, pp.235-8). In the case of the profession the significance of knowledge and more generally scientific knowledge has been discussed above as has the importance of technical and legal rationality; as means of justifying autonomy over the content of work for the profession and the legitimacy of orders for the administrative organisation. The importance of an effective monopoly was discussed above (see page 9) and the heteronomy of clientele is widely recognised. Another means by which ideologies are reinforced is through repeated personal contact, which is an important element in occupational development, since recognition of ideological claims is the means by which professional status is obtained and maintained.

1.5 Contradictions arising from different occupational ideologies within the complex organisation.

The existence of different occupational ideologies and patterns of organisation of work within an organisation threaten the ability of the leadership to determine, implement and adapt policies to fulfil the objectives of the organisation. Green exemplifies a simple model of this proposition by pointing to four possible types of conflict: intra-professional conflict; inter-occupational or professional-bureaucratic conflict; conflict arising from different definitions of goals; and competition for resource inputs (Green, 1975, p.121f). These strands of conflict are interwoven and interact with each other. For instance, competition for resource inputs may be a feature of intra-professional groups who define organisational goals in different ways. Similarly one or more occupational groups may compete for resources within the organisation, especially if these groups aspire to professional status and autonomy over the content of work.

Within an occupation or profession the process of specialisation may lead to the creation of intra-occupational groups which may have a different content of work or practice orientation. Within the medical profession specialty groups vary according to the sorts of medical problems they deal with and also their practice orientation and terms of work. These differences may produce dependent relationships not least because intra-professional groups require a clientele and patients frequently require the services of more than one specialism. Changes in available medical technology or the demand for specialist treatments may alter the pattern of specialisation considerably reducing the size and importance of specialty groups. An example is the treatment of tuberculosis and the gradual reduction in the numbers of doctors dealing with this problem.

Inter-occupational conflict takes place between two or more occupational groups within an organisation. It may be exacerbated by material, political or economic influences from the organisation's environment. Groups may be characterised by professional or administrative ideologies and frequently there are elements of a professional ideology amongst officers in an administrative organisation as more members of professions are organised according to administrative principles to some degree[21]. It follows that the conceptualisation of conflict between two diametrically opposed occupational groups oversimplifies the situation. Additionally the observer may identify conflicts of interest which are not perceived as such by participants. If participants do recognise differences of interest they may not seem either significantly important or capable of amelioration.

Any discussion of inter-occupational conflict between groups with professional and administrative ideologies must recognise that these groups are to some extent dependent upon each other and upon the continuation of the organisation, albeit in a modified form. The benefits of working in the organisation for the profession are: that it provides an effective demand for their services; it provides capital resources necessary for work to proceed; it provides supporting services required in work; and it may provide opportunities for professional training or occupational advancement. The organisation requires the knowledge and skills which the profession possess over which they have an effective monopoly. In many public organisations the state has seen the need to mediate the relationship between client and provider to ensure that clients can afford the services provided. Thus the relationship between occupations within the organisation is complicated by external influences and characterised by patterns of dependency that imply relationships of power. These relationships may well be unequal but not necessarily one-sided.

The question of intra-occupational conflict within a complex organisation requires an understanding of the patterns of occupational differentiation and heterogeneity. The variation in content of work, terms of work, practice orientation and patterns of dependency within an occupation are matters for empirical study. Freidson identified two principles according to which work can be organised - the administrative and the occupational principle (Freidson, 1973, p.19). In organisations characterised by the administrative principle authority is legitimated through a system of offices to achieve rationally ordered objectives (see Taylor, 1947; Simon, 1960; Drucker, 1964). The practicality of rationalism has been questioned by work emphasising the costs of rational procedures and the benefits of incrementalism (Lindblom, 1959). Other writers have emphasised the value of employing rationalising techniques such as limited rationality (Wildavsky, 1964) and mixed scanning approches (Etzioni, 1967)[22]. The occupational principle is seen in professions and crafts where the work group sets standards for admitting and accrediting members often using the apprenticeship model.

Differentiation takes place within occupations organised according to administrative and professional principles of work in the complex organisation. It takes different forms and results in various intra-occupational conflicts. In the administrative occupation subject to powerful external influences it may take the form of disjointed leadership (Braybrook and Lindblom, 1963, p.106), or complex relationships between the centre and periphery (Haywood and Alaszewski , 1980; Mills and Reynolds, 1977). In the profession conflict often takes place between specialist groups with distinctive content or terms of work. These conflicts may cause problems for the leadership in the setting of objectives and ordering of resources to achieve them. The first category to be examined is goal displacement, or a proliferation of goals.

Although it might be expected that goal proliferation is not a problem in the monocratically ordered organisation Merton points to the danger of ritualism in his study of means of adaptation (Merton, 1968, pp.203-7). Where means are more important than ends objectives are sacrificed and the leadership's ability to lead is threatened. Within a complex organisation, with different occupational groups expressing significantly different ideologies resting upon economic ideas, the potential for goal displacement is increased. It is difficult for a leadership from one occupational group to set goals and ensure that they are achieved for three reasons. Firstly, the leadership must take account of the political and environmental pressures which affect the complex organisation. Secondly, the presence of occupational groups with powerful ideologies based on economic ideas, tends to produce a wide range of goals. Thirdly, the differentiation within occupational groups is such that there are important differences in the content of work and the practice orientation between members of the same occupational group. This may facilitate 'divide and rule' tactics by the leadership who need to be aware of the extent to which intra-occupational groups act together, and the significance of sectional interests vis a vis group interests.

In studies of the NHS in the 1970s, Haywood and Alaszewski illustrated the problem of policy drift by demonstrating the failure to achieve a series of specific objectives concerned with increasing expenditure in priority areas (Haywood and Alaszewski,1980, pp.45-54). Although the concern with inputs is criticised, it was demonstrated that the centre was unable to ensure that the periphery implemented central policy decisions. Hunter attributes the non-achievement of explicit policy objectives to the fact that there is no ideological consensus in the NHS and he argues that unitary conceptions of organisations are inadequate

(Hunter, 1980, pp.49-50). Such conceptions of organisations fail to account for the effect of occupational ideologies, the importance of the division of labour, and the disjointed pattern of leadership. It is therefore important to look more closely at the policy-making process within the organisation and the mechanisms which effect the implementation of policies.

In the complex organisation it is frequently the case that professional occupational groups are responsible for implementing at local level policies decided at other levels. Knox has noted that effective health care provision requires the combination of effective medical procedures from doctors, nurses and paramedical staff within a framework of effective patterns of service delivery (Knox, 1979, chapter 13). If one of the components is missing, health care is not likely to be effective. It follows that there needs to be co-operation between professionals and managers if complex organisations are to be effective. In practice managers require the consent of professional groups within complex organisations if they are to achieve their goals.

A further aspect in which there may be ideological conflict between the leadership and professional groups within an organisation is at the level of work orientation. Several professional ideologies stress the importance of the client or the patient while the organisation exists to serve the interests of a community or population. These orientations may clash resulting in the proliferation of objectives. Additionally intra-professional groups may vary in their work orientation and also in their practice orientation. For instance, GPs and hospital doctors deal with individual 'cases' or patients and have practice orientations which reflect this, while community physicians are concerned with the health of specific populations and have appropriate practice orientations.

1.6 Resolving Ideological Conflicts in a Complex Organisation

It was argued above that conflicts which arise in complex organisations (with differentiated occupational groups amongst the employees) prevent the organisation from achieving its goals and therefore hinder efficiency and effectiveness. A solution to these problems has been suggested in the guise of co-optation (Selznick, 1966, pp.13-16).

From the position of the leadership Flanders has summed up the essence of the co-optation strategy very simply, "it is only possible to regain control by sharing it" (Flanders, 1970, p.172). The diagnosis made is loss of control of the organisation by the leadership which was discussed under the problems of policy drift, goal displacement, lack of co-ordination, and conflicting work orientations. Selznick provides a definition of the concept in the introduction to his book TVA and the Grass Roots,

> Co-optation is the process of absorbing new elements into the leadership or policy determining structure of an organisation as a means of averting threats to its stability or existence.
>
> (Selznick, 1949, p.15).

The essence of this strategy, from the point of view of the organisation is that there is some degree of recognition of the threat and its source, and also its importance which requires action to avert the consequences. Two forms of co-optation are identified; formal and informal. Formal co-optation "involves the establishment of openly avowed and formally ordered relationships" (Selznick, 1966, p.13). It takes place under two conditions: where the legitimacy or authority of the governing group is called into question and, where the need to invite participation is largely administrative.

In both formal and informal co-optation the purpose of the strategy is to legitimate the authority of the policymaking or executive group as a means of regaining control. Selznick is fully aware that the sharing of power alluded to may be purely illusory in which case responsibility is shared but not power (Selznick, 1966, p.260).[23] A practical outcome of this is that channels of communication may be established which enable control to be regained with no sharing of power, through consent. Selznick argues that it is in the formal co-optation strategy that the sharing of power is likely to be illusory resulting in nothing more than a 'public relations' exercise.

The strategy of informal co-optation is argued to take place when powerful groups are interested in obtaining real power within the organisation, not simply formal recognition. This power might be exercised according to the second and third dimensions which Lukes identifies, namely, non-decision making and controlling the items that reach the 'agenda' (Lukes, 1974, chapter 4). In this form of co-optation the leadership necessarily concede power to the group posing the threat although it may be argued that they had already lost control of the organisation.

It might be expected that the co-optation strategy, unless of the illusory variety, will lead either to a contraction or to an enlargement of the range of choices open to the new, corporate leadership. The degree of power ceded in the co-optation will be related to the extent of the threat perceived by the existing leadership and the detailed form of the co-optation strategy which is employed. Clearly in a complex organisation there are many levels of leadership and therefore the level at which co-optation takes place may be important. For instance, co-optation may take place only at the local level of an organisation so that power is not ceded at the upper levels where strategic policies are decided.

The appeal of a co-optation strategy lies in the fact that it recognises the dependencies and conflicts inherent within a complex organisation and attempts to deal with them. These dependencies are frequently demonstrated in the questions of resource allocation and policy implementation. Hunter's study of the allocation of development monies examines the problem of competing intra-professional groups without expressly tackling the question of co-optation (Hunter, 1980). For the co-optation strategy to bear fruit it must offer benefits to both the leadership and the group co-opted into the corporate executive. The strategy must be examined in the light of the distribution of power within the organisation and the ideological significance of co-optation as a means of legitimation for the leadership.

In a complex organisation the co-optation strategy may produce an alliance between the leadership and a dominant profession or inter-professional group. This may exclude other occupations or semi-professions since the alliance is able to resist challenges to its authority. The discussion of forms of co-optation is very limited although Selznick does describe one instance in some detail (Selznick, 1966). The details of the co-optation strategy are likely to influence the outcome considerably. The form of participation may vary from 'negotiation' to 'consultation'.[24] Negotiation implies a strong form of participation in which both sides make sacrifices and obtain benefits, while consultation implies an illusory process which may or may not affect the outcome. There are many varieties of participation between the 'extremes' of negotiation and illusory consultation. The forms of co-optation adopted is likely to depend upon the basis of power of the participating group.

CHAPTER TWO

CO-OPTATION AND REPRESENTATION

2.1 Introduction

Chapter 1 concluded that the strategy of co-optation is crucially dependent upon the representative mechanisms which it incorporates . Two forms of analysis are adopted to examine these representative mechanisms: the process of representation and the function of representation.[1] The discussion commences by examining some of the findings from the political science literature. This analysis raises a number of important questions but is unable to answer them all. Role theory is introduced to account for the relationship between representative and constituent, and the behaviour of the representative.

It has been argued that the function of representation within an organisation is to maintain the system (see page 25). Accordingly, this chapter examines the extent to which the representative system underpins the corporate leadership, and allows it to overcome the problems of policy determination and implementation outlined in chapter 1. The processes by which representative authority is legitimated are vital to the outcome of the co-optation process as are the pattern of leadership and the precise form of participation. Finally the form of organisation of occupational groups within the organisation vitally affects the co-optation strategy. Fragmentation and specialisation may act either to increase or to decrease the power of the profession and the leadership within the organisation.[2]

The strategy of co-optation assumes that the contradictions arising from different occupational ideologies within a complex organisation can be overcome through the representative process. This representative process forms the subject of the chapter.

2.2 The Concept of Representation

Many attempts have been made by political scientists to explain the nature of the representative role (see for instance Birch, 1971, 1972; Riemer, 1967; Pitkin, 1967; Eulau, 1959, 1969). The resulting typologies focus on two aspects of the issue: the process of representation, and the function of representation. Riemer's typology is essentially concerned with the process and Birch focusses upon the question of function (Riemer, 1967; Birch, 1972, pp.107-108)[3].

There are several problems associated with the use of typologies in the social sciences[4]. They emphasise theoretical and evaluative judgements about significant aspects of a phenomenon and although useful for comparative analysis do not have objective status. It is therefore necessary to unscramble the assumptions and values upon which a typology stands before it is possible to explain a social phenomenon rather than simply producing a classification. Typologies also assume that it is possible to assign any phenomenon to one category unambiguously which is not always the case. For instance, Riemer identifies four sorts of representative role: the trustee; the delegate; the politico; and the partisan (Riemer, 1967, p.1-6). These terms all have everyday meanings and it is frequently possible to interpret individual representative roles as having characteristics of more than one category.

Riemer describes his representative roles (or ideal-types) in the following way. The trustee acts on behalf of his client, in his client's best interests, because his client is unable or unwilling to act for himself. The delegate is a messenger who acts under instructions or votes in a pre-determined way. The partisan is selected because he holds particular views, or belongs to a party, and he is expected to act in line with those

views. Finally, the politico is a substitute expected to act in accord with his own conscience (Riemer, 1967, p.3).

Each of these 'ideal-types' is recognisable and contains a series of evaluative judgements and expectations concerning a role. They make assumptions about: the representative-constituent relationship; the authority and legitimacy of representative action; the relationship between the representative and non-constituents; and the means of identification of constituents' or representative interests.[5]

The relationship between representative and constituent or constituency commences with the selection process in which the constituent may, or may not, have some part in the selection of the representative. The choice of representative is likely to be limited by several factors including; the number of individuals willing, qualified or competent to stand; the nature of the selection procedure; and the nature of the constituency. The form of selection procedure involved is also likely to be affected by the ability of individuals to fulfil the role, the size of the constituency, the number of candidates and also the importance which constituents assign to the representative role. If constituents see little value in participation then they may show little interest in the selection procedure. Other factors may influence the selection procedure such as the costs and benefits to the representative, whether there are financial or other rewards or costs gained or incurred in the representative role.

The constituent-representative relationship will also depend upon whether the constituent is a relatively isolated individual or one of a collection of individuals sharing common occupational characteristics, or sharing common geographical boundaries. The nature of the link between

constituents in a constituency may be significant since the degree of homogeneity or conversely heterogeneity of constituents will affect the constituency-representative relationship[6]. This study is concerned with the representation of an intra-occupational group and so the representation of an individual is only relevant insofar as that individual is a member of the particular occupational group. The representation of relatively homogenous groups suggests that the representative will find constituent interests easier to discern than in relatively heterogenous groups where these interests differ markedly.

The selection of a representative is likely to form the first element in the legitimation of representative authority. Whether the process takes the form of a ballot or election, or whether it is simply the endorsement of a single candidate there are invariably limitations placed upon the representative. These limitations may be rigid or flexible and frequently include the length of the representative's term of office, the nature of accountability (if any), and the means by which it is rendered, the extent to which the representative may take part in decision-making, and the basis upon which any decisions may be made. These elements of representative authority need not be stated formally, (although they may be included in a written constitution), but they are usually implied and the representative may be challenged if he flouts them.

The legitimation of representative action may also depend upon the characteristics of the representative and the role for which he was selected. For instance, the representative may be selected as an expert with appropriate experience, as a messenger, because of personal attributes of character or skill, or because he shares important attributes such as occupation or citizenship with those he represents. The nature of the

representative's authority will relate to the purpose for which it was given although it can be increased or lost through specific interactions with constituents and others. It is assumed that the selection process enables a transfer of authority to take place from constituents to the representative. Legitimation is also an ongoing process and there may be explicit or implicit methods by which the authority is withdrawn, - the most common being a vote of 'no confidence'. In contrast the constituents' level of interest in the representative process may be so low that he gains authority by default since his function is not highly regarded.

Legitimation of representative action takes place through formal mechanisms, such as selection, and also through informal activities of consultation where the representative and his constituents may review representative action in the light of prevailing circumstances and constituent views and interests. To some extent the representative's authority is dependent upon his past performance which may increase or decrease his authority. The next aspect of representative action concerns his relationship with non-constituents.

The representative is selected to interact with others on behalf of the constituency. The nature of those relationships vary according to the purpose and authority of the representative. For example, the delegate is a member of a decision-making body and authorised to vote in accordance with instructions. He interacts with others of similar status with similar authority. In contrast, the politico acts as a substitute and has a wide range of authority to interact with others as he sees fit. This selection of a representative may imply a range of rights and duties which the constituents do not share. In the co-optation strategy the representative becomes a member of a corporate board or leadership which gives him an executive as well as a representative role .

The last aspect of the representative process to come from Riemer's typology concerns the identification of constituency interests which form the rationale for representative activity. To what extent do representative and constituent views agree? How does the representative act when his constituents have no views, contradictory views, or when their views are different from his? The representative may claim to be able to recognise the constituents' real interests since he has access to material not available to them. He may also be subject to pressures within the decision-making forum from those who have an interest in securing his support. Riemer's four categories of representative each implied a different content to the representative role since they implied different sorts of messages and representative action.

In her study of the concept of representation Pitkin argues that the most important questions do not concern the formal limits to representative authority, but rather, the action of the representative[7]. She poses the qustion, "What does the representative actually do"? as the key to her analysis (Pitkin, 1967, p.112). With this question in mind the contribution of role theory is examined to account for the behaviour of the 'professional representative'. By this term is meant the representative of an occupation organised according to professional, or, to use Freidson's term 'occupational' principles (Freidson, 1973).

It is important to be clear about the terms used in role theory since confusion arises from their incorrect use. The professional representative occupies a 'position', by virtue of selection, that is associated with a range of behaviours referred to as a 'role' (Bradbury,1972, pp.41-43). Jacques argues that it is meaningless to talk of a role outside a framework of relationships since role is a relational concept (Jacques, 1976, p.25) . The 'role-set' comprises all those positions with associated

roles related to the position in question and with whom the occupant of that position interacts (Kahn, 1964, p.13).

Kahn introduces the concept of 'role expectations' and argues that they arise from the dependency of the role set,

> All members of a person's role set depend on his performance in some fashion; they are rewarded by it or they require it in order to perform their own tasks. Because they have a share in his performance they develop beliefs and attitudes about what he should and should not do as part of his role.
>
> (Kahn, 1964, p.14).

These beliefs and attitudes are referred to as 'expectations', and imply that the dependent relationship of the role-set is such that members develop instrumental expectations about each others' behaviour. Kahn continues,

> ... the crucial part of our theoretical view is that the activities (potential behaviours) which define a role consist of the expectations of members of the role set, and that these expectations are communicated or sent to the Focal Person.
>
> (Kahn, 1964, p.15).

In this study the Focal Person is the professional representative whose role is made up of the expectations which members of the role-set send to him. It is not necessary to conclude that the behaviour of the Focal Person is completely imposed upon him by the expectations of members of the role set since the role is those behaviours associated with an organisational position. The professional representative's behaviour does not simply consist of the sum total of all expectations.

Kahn's view of the individual role-episode is misleadingly simple (Kahn, 1964, p.26). A member of the role-set 'sends' an expectation to the focal person. He may comply with the expectation in which case he is rewarded, or he may not comply and risk being punished. The sender may modify his expectation if it is not complied with and send it again, or he may accept defeat. Experience in previous role episodes will inform future influence attempts.

This description is simplistic as it concerns only one expectation while the focal person is subject to many expectations from different sources at any one time. Expectations frequently compete and may actually conflict making the focal person's response more difficult. Additionally, dependency is likely to be two-way in the role set in which case the focal person will have expectations of other members. In the case of the professional representative the constituents' expectations will exist alongside the representative's expectations of constituents in the implementation of policy.

The key assumption underpinning the concept of the role set is that of mutual dependency. This dependency results in the sending and receiving of expectations which are influence attempts. The sending of expectations involves the use of symbolic or material threats or rewards to enforce the expectation, or increase the probability of compliance. The use of resources of power is only one dimension of the role expectation. Gross has suggested a number of dimensions upon which the expectation may differ: the extent to which it is prescriptive or proscriptive; the degree of specificity; the intensity; and the basis of power (Gross, 1958, pp.59-60; Kahn, 1964, p.15). The term 'intensity' refers to the degree to which the focal person is free to choose the most appropriate means to fulfil the expectation. Thus, an expectation with high intensity is one in which the focal person is expected to pursue a particular objective by a predetermined means.

To return to Riemer's categories as examples, the delegate is subject to expectations which are prescriptive, of low magnitude, highly specific and of high intensity. Thus the role is one of messenger in which there is little personal autonomy. In contrast, the politico is subject to expectations of higher magnitude, diffuse nature, and low intensity enabling a wide range of autonomy to be exercised.

The basis of power underlying an expectation only becomes an important issue when the focal person is exposed to conflicting demands. Such demands may occur in the following circumstances. The co-optation strategy is only implemented when there is a group which poses a realistic threat to the leadership of an organisation (Selznick, 1966 p.259).[8] The inadequacies of professional-bureaucratic conflict theory were identified above but where occupational groups hold different, competing, or conflicting expectations the leadership (or in this case the professional representative as a member of the corporate executive and also the profession) will be subject to competing demands. While this strategy is designed to deal with the situation where there are differences in objectives between the leadership and one or more occupational groups, which are sufficiently powerful to pose a threat to the organisation, it does not change the power of the occupational groups concerned nor their objectives. It may, of course, change the means they use to pursue those objectives.

The focal person may also be subject to inconsistent demands from individuals or groups within the role set. The inconsistencies may arise simultaneously or over a period of time but they characterise the intra-occupational or intra-professional conflict referred to by Green (Green, 1975, p.123)[9]. Such conflict is endemic in occupations which are highly differentiated in structure as a result of the process of specialisation. This may cause the representative to experience 'role strain' and thus make the representative position a less attractive proposition.

A number of factors act as intervening variables and affect the relationship between the focal person and other members of his role-set. The question of visibility intervenes in the model of the role-episode

outlined above (Kahn, 1964, p.22). To what extent can the role-sender, or other members of the role set, observe the actions of the focal person and their consequences? At the simplest level it was noted that the representative acts on behalf of the person or group he represents since they are unable or unwilling to act for themselves. Consequently the constituent views from a distance and the degree of visibility is impaired. Additionally the representative role may differ in complexity and it is more difficult for the constituents to observe complex behaviour than to monitor the behaviour of a delegate. Using Gross' terminology, it is likely to be easier to observe the effect of specific expectations of low magnitude and intensity than to observe the effects of diffuse expectations (Gross, 1968, p.59f). Additionally, it may be easier to observe the behaviour of the focal person in some environments than in others. For instance, doctrines of collective responsibility may act to mask the contribution of the focal person (in this case the professional representative) in a decision-making environment.

The relationship between the focal person and other members of the role-set may also be affected by the differences in their access to relevant information. The representative accumulates information and expertise through the activities associated with his position. This information may be unavailable to other members of the role-set or available only at an unacceptable cost. If such information is not available expectations may be diffuse in nature, of low intensity, giving a wide measure of autonomy to the focal person.

The nature of the expectations also depends upon the perceptions of dependency amongst members of the role-set. What saliency do constituents attach to the activities of their representative? From the focal person's

view, how important are the views and expectations of other members of the role set and which are the most important members of the role-set as far as the representative role is concerned. Both sorts of dependency are related to the bases of power to which the role-set and the focal person have access.

French and Raven have produced a typology of the bases of power available to members of the role-set (French and Raven, 1959, pp.155-164). They point to five bases: rewards; coercion; authority or legitimacy; the reference group; and expertise or information. The balance of power between the focal person and his role-set can be examined using these five factors or bases of power. In a complex organisation one would expect the first two bases, namely coercion and rewards, to be exercised in more sophisticated forms than simple financial inducements and force since these are not particularly reliable bases of power. Inducements do however take the form of prestige and status which may be difficult to measure but perceived as important by actors.

The concept of legitimate power (or authority) was discussed in section 1.5 but is a particularly important base of power in the complex organisation. The basis of authority is more problematic for the profession than for administrative occupations which store a range of common beliefs about legitimate power within the organisation. Legitimation is an ongoing problem for the profession and particularly for individual professionals and intra-professional groups[10]. For the representative the extent of legitimate power is limited and transgression of these limits can result in the application of sanctions or even dismissal.

Referent power concerns the influence of the reference group over the individual who identifies himself with that group. Occupational groups may be important reference groups since individuals see themselves as representatives of that group and share in important ideologies. A characteristic of this basis of power is that the target explicitly identifies himself with the reference group and may seek to discover the group's expectations about a particular matter.

French and Raven make a distinction between expertise and information as bases of power,

> Thus we distinguish between the expert power based upon the credibility of O and informational influence which is based on characteristics of the stimulus such as logic of the argument and self-evident facts.
>
> (French and Raven, 1959, p.164).

Both expertise and information may be available as bases of power, to differing extents to representative and constituent. Expertise depends upon the credibility of the expert and the process through which credibility is obtained and recognised depends upon the extent to which ideologies are shared between the representative and his 'constituency'. When expertise is not recognised the content of advice is seen as important and this is judged in relation to existing or comparative information on the subject.

The professional representative is both a target and a source of influence attempts. He has access to various bases of power described above. The resources underpinning the power do not necessarily have to be employed since frequently the threat of punishment or the promise of inducements is sufficient. The question becomes one of credibility (or legitimacy) rather than one of sanctions. The most important bases of power are legitimacy, the reference group, expertise and information and symbolic rewards. The use of material rewards and punishments are least

effective and least important in the context of a complex organisation. The use of these bases of power remains an empirical question for particular representative positions.

2.3 Functional Typologies of Representation

Birch is clear in the status he ascribes to his typology of representative types (Birch, 1971, pp.10-11). The four elements he identifies are logically necessary since,

> ... there is no valid intellectual process by which they may all be put together to form the true nature of representation.
>
> (Birch, 1971, p.11).

The four categories; delegated, microcosmic, symbolic, and elective; are all logically derived from the term representation. For instance X symbolically represents an unknown number, or parliament might be said to be a microcosm of the wider society. A representative role may include elements from each of these types of representation or might fall into one category exclusively.

Birch continues from this analysis to discuss the functions of representation for the organisation or society in which they operate. Apter's earlier analysis suggested three functions of representation: maintaining central control; enabling goal specific ation; and averting threats to the stability of the organisation (Apter, 1968, p.311).[11] Birch suggests that Apter's analysis is too generalised to be of any empirical use since the three categories are insufficiently distinctive. His own typology suggests three main categories and eight functions of representation (figure 2.1). A fully developed representation system will fulfil each of these functions in some measure (Birch, 1972, p.108). The advantage of this typology is that it will facilitate research by increasing

the clarity of discussion, enabling value-free analysis, laying theoretical grounds for generalisations and helping in the construction of frameworks for future research (Birch, 1971, p.125).

The Functions of Representation

Categories		Functions	
1.	Popular Control	(a)	Competitive choice/Election
		(b)	Responsiveness to constituents
		(c)	Accountability
2.	Leadership and Responsibility	(d)	Recruitment of Leaders
		(e)	Enabling leaders to act in a responsible manner
3.	Maintenance of System	(f)	Legitimation
		(g)	Mobilisation of consent
		(h)	Relieving pressure from critics and dissenters

(From Birch, 1972, pp.107-108).

Birch identifies three main categories of functions of representation: popular control; leadership and responsibility; and maintenance of the system. It may be argued that the first two categories can be subsumed under the third. Maintenance of the system was seen by Selznick to be an organisation imperative since failure implied that the organisation would cease to function (Selznick, 1966, p.252). Co-optation was seen as the means of averting threats to the organisation by involving the professional group in policy-making, thus mobilising consent and legitimising policy in one action.

To some extent the representative system, which forms the heart of a co-optation strategy within a complex organisation, has to fulfil all of Birch's eight functions. The extent to which each is fulfilled is a matter for empirical question but in principle, popular control is necessary as the means of legitimising representative authority and the actions of the

corporate executive. Only then can the corporate executive determine policy and ensure implementation since the consent of the professional group is obtained, policies are perceived as legitimate, and implementation may take place.

This analysis makes a number of assumptions about the nature of profession and organisation. Firstly, the professional group are seen as largely homogenous sharing similar perceptions about the major policy issues facing the organisation. If the group is heterogenous, it is less likely to pose a coherent threat to the organisation other than that of anarchy. However, a degree of heterogeneity has implications both for the profession within the organisation and also for the representative. Secondly, the constituents' level of knowledge may prevent them from exercising a large degree of control over their representative. In a study of representatives in the American State Legislature, Wahlke describes one representative as saying,

> People are not capable to tell me what to do - not because they are stupid, but because they have limited access to the facts. If they had the facts the decision would be the same.
>
> (Wahlke et al., 1959, p.274).

Although the respondent appears to make arrogant assumptions, the factor of knowledge is important since constituents are relatively ignorant in certain aspects when compared to representatives who have access to knowledge of particular sorts.

The goal of popular control through selection, ensuring representative responsiveness and accountability, becomes more difficult in a heterogenous constituency and frequently the main form of control is through the selection and reselection process. There may be a body which attempts to exercise a degree of control upon the representative as a proxy constituency, but in a diverse constituency the amount of control may be limited. Control may

mean that limitations to representative action are agreed implicitly or explicitly and transgression by the representative results in some form of censure. In the case of the professional representative the limits may be defined ideologically which does not make them any less effective. To provide more than minimal control the professional group is likely to require specific mechanisms set up for the purpose.[12]

Any co-optation strategy will require a representative system which fulfils Birch's third category of functions; maintenance of the system. Firstly, legitimation of policymaking is necessary if the organisation is to achieve its goals. The process of legitimation involves the other two elements of the functional category namely the mobilisation of consent and the relief of pressure from dissenters. These three functions are very closely related since mobilisation of consent and relief of pressure will need to take place simultaneously in the policy-making process. Where mobilisation of consent and relief of dissent prove impossible in relation to certain policies it may be the case that those policies have to be discarded since implementation is unlikely.

2.4 The Function of Representation in the Complex Organisation

It was concluded in Section 1.6 that the co-optation strategy is designed to avert threats to the stability of the organisation by involving those elements, or their representatives, in the decision-making process. What then are the characteristics of the decision-making process in a complex organisation? In the monocratic organisation decisions are not problematic since they take place within a rationalist framework (see Self, 1977; Edwards III and Sharansky, 1978, Kempner & Wills, 1978; and Allison,1971) and every decision is supposed to contribute to the goals of the organisation[13]. In practice the cost of maintaining a rationalist strategy is high since it is necessary to make a search to identify all

available courses of action and identify the consequences of each one before making a decision on policy. The use of techniques such as cost-benefit analysis, programme planning and budgeting, corporate planning and zero-based budgeting all indicate an attempt to increase the degree of rationality in decision-making while recognising the costs involved (see Hunter, 1980, p.47).

In complex organisations work is organised according to different principles, including the occupational and administrative principles, and therefore it cannot be assumed that goals are shared or that participants pursue goals in the same ways. The rational model does not fit in its ideal form although there may be important elements of rationality affecting policy-making. Another theory of decision-making starts with the assumption that any change is likely to be marginal and therefore rational strategies are expensive and perhaps even immoral in some circumstances (Lindblom, 1959, 1968). Incrementalism tends to be problem based and concentrates on immediate problems rather than distant organisational goals. It is also claimed to be simpler to predict the consequences of marginal change than when change is large-scale and radical. An example of radical change was the reorganisation of the English National Health Service in 1974 where the outcome of important structural changes was difficult to predict. The 1982 reorganisation was in many respects a response to the lack of success of the previous attempt. Lindblom introduces the concept of disjointedness to refer to the fragmented nature of organisational analysis and decision-making that takes place at different levels in the organisation. It is also used in a secondary sense to refer to the use of policies which happen to be at hand rather than involving a search for the most appropriate policies (Braybrooke and Lindblom, 1963, p.106).

Since the co-optation strategy is a device used by the leadership to regain control in an organisation,the first task is to examine the function of professional representation for the leadership. Co-optation would only be expected in a situation where the leadership has lost control or is in danger of doing so because otherwise there is no reason to share the power of the leadership. In a successful co-optation strategy there is a sharing of power by both parties: the leadership share power by co-opting representatives; and the threatening group share power by joining the leadership. The primary expectation of the leadership is that the new corporate leadership will have the power to decide and implement policies within the organisation. The group who are co-opted into the corporate executive gain since they have access to knowledge and information in the formal decision-making arena while they do not necessarily lose the ability to influence the leadership in other ways or to fail to implement policies with which they disagree. This proposition still needs to be tested in practice.

The form of decision-making employed will have implications for the participants in the corporate leadership. The rational decision-making strategies are more costly in terms of commitment by participants and may involve more difficulties in mobilising consent amongst the profession than will an incrementalist strategy advocating marginal change. The degree to which decision-making is disjointed throughout the organisation also affects the success of a strategy where co-optation takes place at one level when decisions are made at several levels by different parties.

The co-optation strategy does not immediately alter the balance of power within the organisation. Groups which posed a threat to the leadership may do so even though their representatives form part of the corporate leadership. It is therefore crucial that the representative can 'carry' his constituents in any matter which they regard as important. Additionally the corporate executive must recognise those decisions in which the representative is not

able to mobilise consent or deal with dissent amongst his constituents. In such cases the co-optation strategy is doomed to failure. It is therefore logical that the condition of consensus is important in the co-optation strategy. If the corporate leadership do not agree, the ability to decide and promote the implementation of policies is lost. Decisions need not be unanimous although they do need to be acceptable, particularly to the representative members.[14] Such consensus decisions may result from compromise or the outcome of bargaining between participants but the central requirement is that they should be acceptable.

The representative occupies a position where he is simultaneously a representative of his colleagues and a member of a corporate executive. Thus two main elements of his role are associated with the position he holds and may result in different forms of role-strain if expectations conflict. The element of threat between occupational groups and the organisational leadership should not be overstressed to the extent that the interests which they share are ignored. The most important interest they share concerns the continuation of the organisation which provides material and symbolic rewards for participants. Many complex organisations also have important shared ideologies which stress the importance of the client, patient, or citizen; and the public image of the organisation as well as the occupational ideologies and the degree to which a professional group threatens the organisation's leadership may be tempered by such considerations.

The next qualification to be made is that there are a number of constraints operating to ensure that certain issues never arise for decision or even discussion (Bachrach and Baratz, 1963; Lukes, 1974). The difficulty of measuring this form of power is not sufficient justification for dismissing it from consideration. It is simpler to recognise instances of non-decision making where policy making is characterised by incrementalism rather than rationalism.

The discussion of co-optation outlined above is subject to a serious qualification in complex organisations since specialisation of function affects both the profession and the other occupational or administrative groups. Intra-organisational specialis ation results in a proliferation of occupational groups who may expect to be represented in the corporate leadership. A representative may have to act for a number of distinct specialist groups who have varied interests and objectives. Specialisation frequently produces relationships of dependency between intra-professional groups such that some groups are relatively powerful and others are relatively powerless. If one intra-professional group is dependent upon another their relationship of power may ensure that a dominant view exists. Where dependencies are differentiated unevenly there may not be a clear range of expectations and the representative may be faced with unclear, competing or conflicting expectations. In such circumstances the representative may be able to act as if there are no clear expectations or employ "divide and rule tactics".

Much of organisational theory has linked administrative organisation with rational decision-making strategies but this does not assist in the analysis of the complex organisation[15]. The preceding discussion has pointed to the professional representative in a complex organisation who, as a member of the corporate executive, takes part in the incremental decision-making which characterises the leadership. The complex organisation operates within an environment which affects the levels of resources available to it as well as the ideological climate in which it operates. Restriction of resources may increase the significance to actors of the allocation processes undertaken by the leadership.

What then are the advantages of the co-optation strategy for participants? Representation allows powerful occupational groups to participate in the formal management structure. It may enable the group to have access to

information and resources which they previously lacked which may be used to underpin the use of power. The precise significance, for the profession, will depend upon the form of co-optation adopted, the place of the corporate leadership within the administrative structure of the organisation, and the use which the profession makes of other bases of power. Participation in formal management structures may enable a positive use of power to pursue objectives as well as the negative use of power to block objectives which can be used outside the formal structure.

The leadership may be able to regain some degree of formal power through the corporate leadership. The success of the strategy will be virtually dependent upon the success of the representative system which is employed. At best the leadership may be successful in the attempt to legitimate the policy-making machinery. At worst they may have given additional resources of power to the profession.[16]

Summary

The discussion of the process of representation made assumptions about the relationships between the representative and constituent, the representative and non-constituents and also the behaviour of constituents. A number of questions which were crucial to the argument point to the need for empirical examination. It was assumed that the constituents would act instrumentally by recognising their dependency upon the representative for certain benefits. It was also pointed out that the patterns of interest among the professional group may vary according to the degree of occupational specialisation and other factors.

The discussion of the function of representation made a range of assumptions about the nature of the complex organisation and the reasons for adopting a co-optation strategy. The ability of the corporate executive to decide and implement policies can only be usefully examined in the light of particu-

lar complex organisations with their patterns of work organisation and associated interests. Nevertheless Selznick speaks of representation as a means of overcoming particular sorts of problems in complex organisations and assumes that the "theory" is applicable in a range of organisations (Selznick, 1966).

The next chapter focuses on an example of co-optation in a very complex organisation, the National Health Service. While there are many instances of co-optation within the organisation, the particular instance chosen is the co-optation of GP members of management teams in health districts and single-district areas which accompanied the 1974 reorganisation of the service.

CHAPTER THREE

THE NHS: CO-OPTATION WITHIN A COMPLEX ORGANISATION

3.1 Introduction

This chapter examines the process of co-optation of the medical profession in the National Health Service. The discussion commences with a review of the forms of medical participation in the policy-making process since the inception of the NHS in 1948. It then proceeds to examine the theoretical roots of the 1974 Reorganisation which was based upon a critique of the existing service and a series of beliefs about the operation of complex organisations. The political statements of policy intention are examined insomuch as they throw light upon the reorganised structure of the NHS. The chapter concludes with an examination of the available evidence on the role of medical representatives in NHS management, focussing on the role of the General Practitioner (GP) team member.

3.2 Medical Participation in NHS Management since 1948

The 1946 National Health Service Act laid the foundation for a tripartite health service which commenced on 5th July 1948. From the outset it was recognised that doctors should participate in the management and administration of the service (Great Britain Parliament, 1946). The reasons why a tripartite service was created have been described elsewhere but one effect was that doctors in each arm of the service had different "terms of work" and "practice orientations" (Eckstein, 1964; Forsyth, 1966; Pater, 1981; Watkin, 1978). General Practitioners (GPs) and other independent practitioners were represented through the Local Medical Committees (LMCs) retained from the pre-NHS era . The LMCs advised the Local Executive Councils which held and administered the contracts of independent practitioners. The community services were largely under local

authority control with a Medical Officer of Health (MOH) who acted as chief officer.[1] In the hospital service it was immediately recognised that employed staff should advise the Hospital Management Committee (HMC),

> ... committees representative of different groups of staff should act as advisors to the HMC and these should be constituted by staff and not appointed by managers.
>
> (HMC(48)1)

This circular recognises that medical staff should have the right to offer advice to the Hospital Management Committee. The main advisory committee in hospitals was the Medical Staff Committee (MSC) and circular RHB(53)91 suggested an 'agenda' for these committees,

> ... these bodies should discuss:- allocation of beds, admission criteria, equipment and supplies, development of the scope of hospital's work, also (tentatively) systematic review and analysis of clinical work.
>
> (RHB(53)91)

Thus the main area of advice concerned the organisation and development of hospital specialist services and there was also the suggestion that medical audit might be appropriate .

In the early years of the National Health Service doctors participated in the policy making process in different ways in each of the main branches of the profession. GPs were represented through the Local Medical Committee, hospital doctors formed advisory committees, and community doctors were organised in a hierarchy under the Medical Officer of Health.

The Bradbeer Report in 1954 indicated a movement from the participation of medical staff in advisory committees to participation in administration. The committee were charged with reviewing,

> ... the existing methods of administration in Hospital Management Committee Groups with particular reference to the extent to which administrative duties should be undertaken by medical and nursing staff.
>
> (Central Health Services Council, 1954).

The report distinguished between administration and management. There was no place for the medical superintendent in the hospital but there was an important role for the medical administrator. The distinction was based upon the view that management involved classical line-management relationships which were not appropriate between hospital doctors but that doctors should be involved in the organisation of the service. The report also emphasised three elements of hospital management: lay or business administration; nursing administration; and medical administration. (These findings bear a strong resemblance to the emphases of the 1982 restructuring of the NHS.)[2]

The appointment of the medical administrator was to be approved by the Medical Staff Committee (MSC), the Hospital Management Committee (HMC), and the Regional Hospital Board (RHB). The position was of limited tenure but the occupant needed sufficient authority to enable him to fulfil his duties. This authority was not of a managerial nature but corresponded to the co-ordinating and monitoring variety discussed in section 3.4 (Jaques, 1978, pp. 323-4).

The findings of the Bradbeer Report are in keeping with the discussion of the nature and assumptions which underlie professional work and the appropriate relationships between professionals and with other occupational groups and clients[3]. Lay Administrators could not exercise authority over doctors, even of the monitoring or co-ordinating varieties. Doctors could not manage the work of their colleagues. The credibility

of the medical administrator lay in the fact that he was an active clinician temporarily involved in administrative duties. His authority was limited by his short tenure and rested upon conventional ecumenic ideas such as clinical experience and seniority rather than administrative skill. Each of these principles has remained important in subsequent discussion of medical participation in management and administration .

In 1956 the Guillebaud Committee inquired into the cost of the NHS and warmly endorsed the findings of the Bradbeer Report (Ministry of Health, 1956). It also suggested a national training scheme to improve the status of hospital administrators thus emphasising the importance of management alongside medical administration[4] . In 1962 a committee representing the medical profession called for the unification of the National Health Service (Royal College of Physicians, 1962)[5] but this was overshadowed the following year by the Gillie Report which advocated the development of family practitioner services and the co-ordination of community care through the GP (Central Health Services Council, 1963).

Perhaps the most important report of this period was the Hospital Plan for England and Wales published in 1962 (Ministry of Health, 1962).[6] While it took account of the interdependence of the three parts of the health service, it also introduced the concept of the District General Hospital around which the health district was formed in the 1974 reorganisation of the NHS. The presence of a full range of services, preferably located on a single site was an important element in the creation of divisional structures within the medical advisory system in England and Scotland (Ministry of Health, 1967; DHSS, 1972; DHSS, 1974).

The Joint Working Party on the Organisation of Medical Work in Hospitals produced its first report in 1967. It was widely referred to as the 'Cogwheel Report' due to the distinctive logo on the cover of its

reports. Its remit was,

> To consider what developments in the hospital service are desirable in order to promote improved efficiency in the organisation of medical work.
>
> (Ministry of Health, 1967, para.1).

The chief problem identified by the working party was that of co-ordination. Particular examples were identified such as the relative isolation of the three branches of the NHS (Ministry of Health, 1967, para.5) and the competing patterns of demand for scarce resources such as theatre time (Ministry of Health, 1967, para.6). In response to this diagnosis the following question is raised,

> What contributions can practising clinicians make to the management and administrative arrangements of the hospital complex?
>
> (Ministry of Health, 1967, para.2).

The introduction of the word management emphasised the recognition that clinical decisions involved the management of resources although doctors might not perceive them in that way (Ministry of Health, 1967, paras. 31-2). The deficiencies, from a management perspective, of the medical advisory system were discussed and it was argued that clinical and management decisions are interdependent (Ministry of Health, 1967, para.35). The solution proposed was structural with a range of specialist divisions as its base and a Medical Executive Committee (MEC), composed of the chairmen of divisions, undertaking co-ordination (Ministry of Health, 1967, chapter 7).

The structure required a high degree of participation from hospital consultants and limited participation by General Practitioners (GPs) and Clinical Medical Officers. It assumed that the chairman of each division would be given authority to represent their colleagues on the MEC which had important executive as well as advisory functions. A second report was

published in 1972 which commented on the widespread failure to introduce Cogwheel Systems as recommended in the first report (DHSS, 1972, para. 7.1 - 7.4). Some hospital groups had introduced part of the Cogwheel system alongside the existing Medical Staff Committees which they were expected to replace. It was not uncommon to find MECs with no divisions and divisions with no MECs thus defeating the objective of co-ordination (DHSS, 1972, para.7.2).

In response to the disappointing level of implementation of complete Cogwheel Systems, the second report appeared to dilute the message of its predecessor since it emphasised that structural changes might not be the most important response to the reports. It was argued that,

> The quintessence of Cogwheel is to be found as much in the attitude of mind of those who embrace change as in the structures they adopt.
>
> (DHSS, 1972, para. 4.1).

This impression was reinforced by the call for 'universal adoption of systems based on the Cogwheel philosophy' (DHSS, 1972, para. 1.3). The second Cogwheel Report emphasised the importance of local variations in the historic provision of capital resources which militated against the imposition of identical solutions in different hospital groups. However it is important to note that the divisional system did allow for a certain amount of flexibility since it did not set out which specialties should form divisions or whether divisions should be made of combinations of specialties. Such flexibility was only recognised in the Chief Medical Officers' Working Party which reported on District Arrangements for Medical Advisory Machinery in 1981 (DHSS, 1981).

The second Cogwheel Report can also be seen as a link between the first report and the report on Management Arrangements for the Reorganised NHS usually referred to as the Grey Book. (DHSS, 1972a). It argued that

Cogwheel systems would be essential if structural changes of reorganisation were to be successful (DHSS, 1972b,paras. 3.2, 3.3). The justification for adopting Cogwheel systems bore a close resemblance to the analyses produced by the Brunel Institute of Organisation and Social Sciences (Tolliday, 1978, pages 35-7) in their discussion papers which are discussed in section 3.4 . The dominance of one profession within an organisation results in autonomy for its practitioners and causes problems for the leadership in policy determination and implementation. Clinical decisions have administrative and managerial consequences and therefore corporate planning and management is necessary for ensuring co-ordinated and efficient services. Staff must have confidence in the corporate structure and spokesmen require sufficient authority to represent their colleagues in negotiations and discussions, and to provide 'executive leadership' (DHSS, 1972b, para. 3.5).

This representative with executive authority is seen as the lynchpin of collaborative arrangements in the new service,

> Collaborative arrangements must make provision for widespread consultation and dissemination of information - that is there should be a sensitive and responsive system of internal communication - but they must also produce representatives with the ability and determination to use the discretion vested in them by their colleagues as a basis for action.
>
> (DHSS, 1972b, para. 4.8).

Thus the representative's authority depends upon personal qualities, the selection process and the representative system. The representative is not a manager of his colleagues although he is part of a corporate Medical Executive Committee (MEC) employing rational management techniques (DHSS, 1972b, para. 4.9).[7]

The Medical Executive Committee (MEC) was described as a committee concerned with the implementation of policies but it was also concerned

with policy determination, performance review, audit, and co-ordination of divisions (DHSS, 1972b, para. 4.9). The concept of clinical autonomy is not threatened since it is restricted to the individual therapeutic decision (DHSS, 1972b, para. 3.4). Even the single decision commits scarce resources and has an opportunity cost. Thus the members of the Medical Executive Committee (MEC) are involved in a range of management activities but they need to respect the clinical autonomy of their colleagues at least in the sense of individual autonomy.

The means by which the MEC pursues its objectives are primarily persuasive (DHSS, 1972b, para.4.9). It was however suggested that individual clinicians might be persuaded to support policies agreed by their colleagues (DHSS, 1972b, para. 4.9). The clinicians maintained their right to dismiss their representative if he acted in an unsatisfactory manner (DHSS, 1972b, para.4.5). In summary, the Second Cogwheel Report argued that collaborative arrangements depend upon the distribution of knowledge, the efficacy of systems of communication and the ability of the representative (DHSS, 1972b, para. 4.8).

The discussion of role theory pointed to the problems of knowledge and visibility (see chapter 2, pp. 33f). The extent of constituents' knowledge was related to the degree of visibility and acted to constrain or facilitate the relationship between constituency and representative. Additionally the success of the collaborative arrangements envisaged in the Second Cogwheel Report depended upon the acceptability of the structure to the participants - in this case hospital consultants. Since the MEC's powers were largely persuasive and dependent upon peer group pressure, it was necessary to persuade consultants that participation in such a structure was in their own interests and those of their patients.

The remaining factor underpinning the success of the Cogwheel system was the ability and determination of the representative. The personal qualities identified included charisma and experience and the selection process involved the personal authorisation of the individual to act as representative.

The report argued that discretion was vested in the representative at selection but legitimation was also an ongoing process related to performance to the extent that such performance was visible (DHSS, 1972b, para. 4.8). The representative was more than a delegate or messenger since he made judgements on the basis of this discretion.

The Second Cogwheel Report anticipated the reorganisation of the NHS by asking for co-ordination of hospital and community services. Evidence from a survey of 126 hospital groups demonstrated that only a few had general practitioner members and many of these belonged to divisions solely concerned with hospital services[8]. General practitioners were encouraged to participate in specialty divisions rather than through separate GP divisions so that co-ordination of hospital and community services might take place (DHSS, 1972b, para.5.13).

The most specific guidance about medical participation in NHS management came in the document 'Management Arrangements for the Reorganised Health Service' generally referred to as The Grey Book (DHSSa, 1972). This was intended as a consultative document but attained greater status since the foreshortened time for consultation meant that it assumed the role of a structural blueprint for the service (DHSS, 1972a, foreword). Two sorts of medical participation were identified in the roles of the community physician and the clinician. (It is the participation by the clinician which is of concern in this thesis.) The value of the clinician's participation is attributed to his role in the active practice of medicine

and innovation in patient care which has implications for service provision. Participation in the management system was expected to improve the quality of management decisions and the commitment of clinicians to these decisions (DHSS, 1972a, para. 4.1).

Participation in management diverts clinicians from their primary activity - patient care. Mason does however qualify this point by demonstrating that consultants frequently cut research and teaching activities before their clinical sessions (Mason, 1976, page 37). Nevertheless since the time given to patient care was threatened it was important that management activity by clinicians should be efficient maximising the benefits while minimising the costs of participation. Medical advice was to be provided by a single multi-specialty committee chaired by the clinical members of the management team. Thus representative clinicians were to be full members of the corporate management team which resembled Selznick's picture of formal co-optation. The role of the clinical team members was described in the following extract,

> As full members of the DMT, the DMC representatives will take part in all its discussions and decisions. As team members they are party to the consensus decisions of the team and share in its collective duties and joint responsibility. But, unlike other members of the DMT, they take their places not as heads of hierarchically-organised professions but as elected representatives of equals. They must enjoy the confidence of their colleagues, so that they can speak for clinicians not as mere delegates, unable to commit their peers without reference back, but as representatives using the discretion vested in them as a basis for action. Only when clinicians give and accept the confidence of their colleagues in this way can they collectively play their full part in management decisions, many of which concern them vitally.
>
> (DHSS, 1972a, para. 4.10).

The role of consensus, by which the management team is bound, protects the autonomy of the clinicians but implies a degree of flexibility by the clinical representatives in decision-making. The clinical

representatives need the ability to distinguish between courses of action which will and will not be acceptable to their colleagues. It does need to be recognised that only a proportion of DMT or AMT decisions will affect clinicians in a direct form.

In conclusion, the form of medical participation adopted for the 1974 Reorganised NHS involved clinical representatives whose authority was essentially uncertain depending upon the extent to which their actions were acceptable, or at least not unacceptable, to their colleagues.

3.3 The 1974 Reorganisation of the NHS

Two categories of decision can be identified which influenced the form of the 1974 reorganisation. Major political decisions were made or existing practices remained unquestioned concerning issues such as the separation of NHS and Local Authority services and the administration of the Family Practitioner Services. Decisions concerning the details of the reorganised service were dependent on political intentions and prevailing views about the nature of complex organisations. This section is primarily concerned with the first category of decisions and the detailed nature of the reorganisation is discussed in section 3.4.

Undoubtedly the primary objective of reorganisation was to facilitate unification of the three branches of the service to enable rational planning and comprehensive management and delivery of services. Kenneth Robinson argued that unification was the central theme of the 1968 Green Paper (Ministry of Health, 1968, page 6) and it was also one of the four main principles outlined in Crossman's Green Paper (DHSS, 1970, para.6). This theme was accepted in the consultative document produced by Sir Keith Joseph and also in the subsequent legislation (Great Britain Parliament, 1973). Unification was seen as the means of achieving effective co-ordination and delivery of services and also efficient administration.

The next objective was that there should be effective central control of NHS services while not stifling the opportunity for local initiative. This was one of Crossman's four principles and also underlay much of the discussion of structural issues (DHSS, 1970, para.6). The rising cost of the NHS was a significant factor in the pressure for central control, although there was also the intention that local developments should be consistent with national priorities (DHSS, 1970, para. 6, iii). It followed that Health Authorities were to have the maximum responsibility for the planning and management of services insofar as this was consistent with national priorities. There were three membership categories in the new authorities; representatives of the medical and related professions, local authority nominees, and nominees of the Secretary of State. In the 1971 Consultative Document Sir Keith Joseph coined a phrase which echoed many times during the reorganisation and summed up this objective. The NHS was to be characterised by,

> a clear definition and allocation of responsibilities, with maximum delegation downwards, matched by accountability upwards.
>
> (DHSS, 1971, para.6).

The next objective, closely related to the question of central control was that of effective management throughout the service. The influence of theories of scientific management was clear to see in the foreword to the 1971 Consultative Document in which the NHS was referred to as 'one of the country's largest enterprises' (DHSS, 1971, foreword). The influence of rational theories of management was clear in the 1972 White Paper which called for,

> a wide, unbiased and constructive view of priorities across the whole range of needs,
>
> (DHSS, 1972, para.9).[9]

Clearly the model of organisations which was implied emphasised concepts of rational decision-making, not the political aspects of organisations.[10] It was recognised that an unbiased review of priorities required a balanced health authority membership without medical or local authority dominance.

At the operational level of management it was important to examine how day-to-day decisions were to be made. The Hunter Report emphasised the interdependent nature of the division of labour within the NHS,

> No single group of staff can have more than a part of the knowledge needed to make integration a success.
>
> (DHSS, 1972c, para.14).

Two implications of this statement are that some form of co-operation is needed in management between staff groups and also that combined knowledge forms the basis of the reorganised service. The 1970 Green Paper spoke of the need for "careful teamwork between several professions and disciplines" making implicit assumptions about the relative status of different occupational groups (DHSS, 1970, para. 71). Co-operation between consultants and GPs was especially emphasised since it was recognised in 1970 that these two occupational groups were not likely to be employed on similar contractual bases.

The 1972 White Paper asked how the public would gain from the reorganisation of the service. The answer was given that,

> a more informed judgement of priorities will concentrate more of the available resources where they are needed
>
> (DHSS, 1972d, para. 204).

The emphasis on selective concentration of resources assumed that decisions concerning priorities required appropriate information and

participation in their making. The alternative view is that such decisions are value-judgements which are essentially normative and not amenable to rational decision-making techniques since the objectives of health services are far from being clear.

The final objective of NHS reorganisation was that there should be co-ordination between services provided by health authorities and local government authorities. The most important aspect of local government services were the social services but services were also provided in the areas of housing, environmental health and education in which co-ordination might be necessary. Geographical co-terminosity at the county or Metropolitan borough level was regarded as an important means to achieve this co-ordination although it was not regarded as important in the 1982 reorganisation.[11] Joint Consultative Committees were set up to assist in the co-ordination of services and joint finance was produced for projects which benefitted both services.

3.4 The Theoretical Roots of Reorganisation 1974

The reorganisation resulted from a complex interaction of many different pressures over a period of years. It cannot be attributed to a single set of theories about the nature of complex organisations and it would be foolish to attempt to do so. Two sorts of theoretical roots can be identified; the implicit understandings of the nature of organisations in the proposed management arrangements, and the views of the management consultants gleaned from discussion papers and books published subsequently. This section will concern itself with the contribution of the two theoretical strands which came from the management consultants appointed to assist in producing proposals for the detailed management arrangements for the reorganised service.

Two groups of management consultants were employed to advise in the production of proposals for management arrangements. The Brunel Institute of Organisation and Social Studies (BIOSS) provided an influential analysis of the nature of complex organisations based upon the technique of social analysis and the McKinsey Corporation were asked to advise because of their experience in commercial organisations and also their work with other health services. Much of the work by BIOSS has been published in various forms and so their theories are more readily available than those of McKinsey which have to be deduced from other sources.

The BIOSS analysis starts with the assumption that the NHS is an ultra-complex organisation or social institution (Rowbottom, 1977, p.28 note; Jaques, 1978, chapter 1). The complexity arises from the fact that it has a large number of functions, deals with a large number of clients who have a wide range of problems, and employs many different groups of staff of different disciplines. The analysis also assumes that many basic ideas from developments in the NHS in the sixties are fixed and these are not questioned. The concept of the district with its own district general hospital providing a full range of services for a population of 250,000 is one of the key assumptions of the work. This acceptance of a range of immutable features is one of the chief characteristics of the method of analysis which was termed social analysis (McDonald & Otto, 1978; Rowbottom, 1973, pp.276-300).

Social analysis is a form of action research in which the client invites the analyst to assist him to answer a particular problem. Rowbottom identifies three key elements of the approach: the relationship between analyst and client is collaborative; the researcher's role is essential analytic; and the research is concerned with organisational problems rather than personal or personality difficulties. Consequently

the 'research report' takes the form of an analysis rather than a list of recommendations and this is presented to the client for reanalysis. McDonald and Otto describe the product of their analysis in the following way,

> Consequently the collaboration ensures that any public research reports are jointly agreed statements about real working situations.
>
> (McDonald and Otto, 1978, p.368).

Thus, the work is concerned with change which takes place when the client and analyst have agreed upon the diagnosis and solution to the problem.

Previous work on the organisation of hospitals had been carried within BIOSS and was described by Rowbottom in the following way,

> Our work so far has concentrated on purely organisational issues - what roles particular groups and individuals play, and how these roles do (or do not) bind together as one system in forwarding the work of the hospital as a whole.
>
> (Rowbottom, 1973, p.5).

This emphasis accepts organisational objectives and those of groups within the organisation rather than the wider objectives of providing health services to a population or evaluating the output or outcome of the organisation's activities. This limitation of the role of the analyst is recognised by Rowbottom but still remains serious,

> Our work is not concerned with an independent critical evaluation of the services received by patients. It is avowedly about how hospital staff can be helped to organise themselves in ways which are more effective <u>according to their own definitions of appropriate functions</u> subject to the ultimate sanction of higher authorities.
>
> (emphasis in original) (Rowbottom, 1973, p.6).

By restricting their analysis to the staff's own definitions of appropriate functions the assumption is made that staff have sufficiently well developed views of their functions to be able to measure

effectiveness. It is also assumed that different groups of staff have objectives which do not conflict or can be reconciled according to organisational objectives. It was suggested above that different occupational groups and even different groups within a profession may make claims to dominance in a particular field and therefore their views of appropriate functions may differ and also their views of the legitimacy of particular forms of authority.

The BIOSS work deduces a system of descriptive concepts from the actors' definitions with which they commence and these are used as building blocks which can be applied to present or future organisation (Rowbottom, 1973, p.66). The crucial building block which they use in their discussion of the NHS is the concept of clinical autonomy. Like other professional occupations the medical profession seek autonomy over the content of work and this is justified through the idea of clinical autonomy. This corresponds to Engel's idea of individual autonomy in the first instance (Engel, 1968). Cang writes about clinical autonomy in the following way (Cang, 1978, pp. 3-5). The onset of illness makes a patient vulnerable and to protect that patient the NHS recognises the importance of personal care by a doctor who takes sole responsibility for that patient. He cannot be overruled by a superior (unless he is still regarded as being within one of the training grades) whether that superior is a senior doctor or an officer of the health authority. Thus the doctor's autonomy extends to the individual therapeutic decision for the patient.

The consequences of this autonomy are then deduced logically from the premise of clinical autonomy. The patient knows that a named doctor is responsible for his care while he is incapacitated. The doctor knows that he cannot be overruled in individual clinical decisions and therefore is

said to have 'unmanaged status'. Since this unmanaged status is given to protect individual patients the service specialties such as pathology and radiology and specialties such as community medicine which do not have responsibility for individual patients are frequently organised in managerial hierarchies. There are a number of objections to this line of argument but to follow it to its conclusion it is argued that it is not appropriate for those doctors who take responsibility for the care of patients to be organised in management hierarchies.

The definition which BIOSS adopt to describe a managerial relationship is important in understanding the significance of their argument,

> A managerial role may arise where it is wished to make a person A. fully accountable for the work of another or others, B.
>
> (BIOSS, 1977, R.1989).

It follows that B is accountable to A for every aspect of his work since A is accountable for that work to a higher authority. Since this view of a managerial relationship entails a principle of authority which is more difficult to envisage in practice having a wide range of applications it was necessary to introduce the concepts of monitoring and co-ordinating authority.

This argument is therefore that doctors cannot be organised in hierarchical relationships to other doctors or to administrators or managers since, because of the principle of clinical autonomy which has been accepted by the NHS, no other person whether medically qualified or not can be responsible for every decision the doctor makes. The responsibility for each individual decision remains that of the doctor alone. It is clear that the analysis produced by this method is based upon the ideology of the medical profession but still needs to find some means of accommodating the need for leadership within the organisation particularly

since the medical profession is responsible for an important range of spending decisions within the service.

It was on the basis of this principle that the discussion turns to the most appropriate form of leadership for the NHS (BIOSS, 1973, pp. 42-43).[12] Four main sorts of leadership were considered: the chief executive officer (CEO); the general manager and coordinator (GM/C); the area or regional coordinator (A/RC); and the functional or general coordinator (DA/AA). Each of these roles implies a different relationship between the leadership and the different occupational groups within the organisation. The CEO was regarded as inappropriate since the role challenges the principle of clinical autonomy. The role of the chief executive had been acceptable in the reorganisation of local authorities in 1974. It did imply that the service would be organised in a managerial hierarchy which would not be acceptable to the medical profession even if the CEO were medically qualified as were the medical superintendents in pre-NHS hospitals. The GM/C implied that one man would be responsible for managing the non-medical aspects of NHS organisation and for co-ordinating the medical work of doctors. While not challenging clinical autonomy in the strict sense used by BIOSS it was felt that no single person could be responsible for the whole range of non-medical services. The A/RC implied that the professional autonomy of the medical profession would be threatened and also the functional autonomy of the other occupational groups which left the post of the functional and general coordinator who was termed the district or area administrator.

Thus the District Administrator was to co-ordinate the work of the managers of the main functions which at district level were defined as nursing, finance, administration, and services provided by the medical profession. While medicine was not strictly organised according to a

functional model it was represented by three doctors from the main branches of the profession: community medicine, hospital medicine, and general practice. Since community medicine does not provide services direct to the patient it had a functional manager - the District Community Physician (DCP) or the Area Medical Officer (AMO). He acted as a functional manager and had officer status along with the chief officers of the other functions. Those doctors who provided personal services to patients could not be subject to a functional manager and therefore were to be represented by one of their number and since there was a difference in practice orientation between hospital and family doctors there was to be a representative of each.

The representatives of GPs and hospital doctors were to be members of a collective chief executive (Alaszewski, 1981) with equal standing to the functional managers.[13] The District Administrator or Area Administrator had the role of functional or general co-ordinator although this did not necessarily mean that he was chairman of the management team. The analysis did however assume that the representatives of doctors could play a similar role for their 'discipline' as the functional manager for those he managed. This assumption was a crucial one since it encapsulated the tension of the professional representative. The functional manager could ensure that decisions of the management team were implemented since he managed the function himself and was recognised as having authority to ensure that orders were implemented. The medical representatives could not rely upon administrative authority to ensure that their medical colleagues complied with team decisions and therefore were dependent on other forms of authority to gain compliance.

The involvement of doctors in management or administration was not a new theme and had been recognised by the service for many years. It

was argued by BIOSS that all doctors took part in the management process in two ways,

> All doctors take part in the 'management process' and are affected by it; they continuously make decisions which expend resources, and they take part in committees which influence policies and plans.
>
> (BIOSS, 1973, p.14).

The management process is taken to include both the activity directed to making conscious policies and also the therapeutic decisions which are implicitly expenditure decisions and cumulatively have the effect of constituting the operational policy of the organisation. The implementation of policies depends upon the total of individual clinical decisions and therefore if such policies cannot be enforced by the leadership some other mechanism is needed to achieve compliance. BIOSS make this distinction between the management process and management since it is important to the integrity of their argument that doctors are not regarded as being in a management relationship with individuals or committees. They argue that,

> ... they (doctors) take part in committees and sub-committees by means of which they influence policies or plans, and sometimes decide actual expenditure or use of resources; these decisions are sometimes called 'management' decisions but they are really committee policy decisions which, although they affect doctors, do not mean that the committees or officers are the managers of doctors.
>
> (BIOSS, 1973, p.16).

In the context of the earlier definition of a management decision or relationship doctors are not held accountable for the whole of their work either to committees or to officers. Their work is however, subject to policy decisions concerning the volume of resources available with which to carry out their work which in effect constrain the autonomy of the physician to operate as he wishes.

Two sorts of authority are identified which account for the authority of committees and management teams to create policies without implying that the doctor is fully accountable to the committee or team. Monitoring authority enables a committee or officer to observe the activity of the clinician and report to the clinician or higher authorities if the clinician's performance is not in accordance with policies. An example of this is the power of the FPC Administrator to act on the basis of complaints received from patients about a GP's activities and another is the role of the Regional Medical Officer (DHSS) to review the prescribing practices of GPs and to take action if he feels a GP is prescribing excessively. In neither case does the officer have the authority to prevent the GP from following a particular course of action as in a managerial relationship but he can institute procedures to attempt to modify the GP's actions. In the case of co-ordinating authority the officer or committee is recognised as having the authority to attempt to persuade different functions or specialties to cooperate to achieve organisational goals but he cannot order one specialty to comply as in the case of administrative authority (BIOSS, 1973, p.23).

It follows that clinical autonomy cannot be regarded as an unchallenged feature of medical practice since there are a whole range of constraints upon the activity of doctors ranging from the law of the land to the contractual relationship with the employing body which actually affect clinical practice. Therefore the management team is not a collective chief executive according to the BIOSS reasoning since it is characterised only by co-ordinating authority to co-ordinate sections of the organisation characterised by functional and clinical autonomy respectively. The argument is summed up as follows,

> In short consultants and GPs do not have managers. But, they may be monitored and coordinated by medical and non-medical administrators, by their own or elected representatives, and by the employing authority. This monitoring authority is not the authority to instruct. It is persuasive authority, but none the less real for that. And they are affected in their demand for general resources by the extent to which they themselves can persuade their colleagues to agree to give support to priority for their requirements.
>
> (BIOSS, 1973, p.23).

This thesis is concerned with the extent to which medical representatives are able to obtain and exercise such authority in the production and implementation of policy.

3.5 The Role of the Medical Representative in the Reorganised NHS

Although there has been a limited amount of speculation about the role of the GP and consultant members of the management team, there is little evidence about their performance. It has been suggested that there is an ambiguity in the Grey Book account of the role and also in the minds of the medical profession and indeed this ambiguity is the central aspect of the role (Eskin, 1979, p.35). The clinical members of the management team are representatives and members of a powerful, relatively autonomous professional group and also full members of a management team. One important commentator takes the following position with respect to the role of the GP team member,

> The important point here is that there will be a general practitioner voice, someone who is party to all the decisions and thinking; no doubt gradually the true value of this collaboration will emerge and be taken advantage of.
>
> (Burbridge, 1973, pp.43-4).

In terms of the discussion of representation, the GP member resembles the BIOSS concept of a type-representative or Birch's type of microcosmic representation (BIOSS, 1978; Birch, 1971). In essence, the 'representative'

is himself a GP subject to the troubles and interests of his colleagues and might be expected to speak as any other GP in that locality. Additionally he is a source of information for the team and also for his fellow GPs. The exchange of information through good communication systems was widely seen as the key to collaboration or co-ordination depending from where the process is viewed.

The first research paper presented to the Royal Commission on the National Health Service, widely referred to as the Kogan Report after its principal author, reported a wide range of views concerning the role of the clinical members of the management team. The most important element of these views was the degree of authority which doctors were prepared to give to their clinical representative (Royal Commission, 1978, para. 9.6). In a study of the reorganisation of the NHS in Humberside it was concluded that,

> Representation involves some surrender of power to the representative and it was clear from our interviews that many doctors could not accept this.
>
> (Brown, 1979, p. 138)

This surrender of power was mentioned in the discussion of the legitimation of representative power which takes place partly through the selection process but is also an ongoing activity. Larson has commented that consultants were unhappy to surrender power to their colleagues on Cogwheel Divisions or the MEC (Larson, 1974, p.11). Alaszewski gives a case study drawn from one district general hospital in which the consultant clinical representative was unable to speak for his colleagues since there was no single consultant view (Alaszewski, 1981; Heywood and Alaszewski, 1980). The issue concerned the allocation of beds in a new phase of the hospital development and the main problem was that consultants could not agree how the beds were to be distributed.

This highlights the important question of the nature of the medical consensus, the significance of intra-professional groups, and the nature of interests amongst professionals working in complex organisations.

The assumption which underlay the representative system outlined in the Grey Book is that hospital doctors, GPs, and community physicians have significantly different interests due to differences in function and practice orientation (DHSS, 1972a). It is also important to note that there is significant variation within functional categories especially in the case of the hospital doctors and GPs. Indeed the hospital doctor and GP functional categories include practitioners with widely differing interests; in the case of the hospital doctors this results from specialty and practice considerations while, in the case of the GP, it results from differences in practice organisation and geographical factors. While there are differences of interest within the medical profession which operate on functional lines there are also problems which relate to the professional-administrative distinction.

It has been argued that the interests of doctors and managers are frequently opposed,

> ... it also points to a basic management problem, that of providing the practitioner with what is needed to treat his patients while simultaneously ensuring the overall well-being and equitable distribution of resources of an organisation. Management and practitioners 'pull' in different directions.
>
> (Royal Commission, 1978, para. 1.16).

Although managers and clinicians have different objectives and occupational ideologies, it is important that the interests which they share are not ignored. Conflicts of interest do arise from time to time and Kogan argues that clinical autonomy must be compromised to the goal of effective and fair management (Royal Commission, 1978, chapters 8,9).

The medical representative may stand at the focus of this conflict in which case his role is at best difficult and sometimes closer to impossible.

A consultant has written that the relationship between clinicians and managers is such that the medical representative cannot be held responsible for his colleagues (Devlin, 1979, p.10). Other commentators see the role as unrewarding and potentially alienating from the representative's clinical colleagues (Royal Commission, 1978, para. 9.16; Eskin, 1979). Time spent on management activities has been interpreted by some as the diversion of of qualified doctors from patient care - their proper function - to management which is seen as a less valuable activity (BIOSS, 1978; Goldsmith, 1972, p.606). It has been argued that the management team may perform two sorts of activity: general management or executive management (Nuttal, 1974, pp.54-57). General management concerns the policy-making activity and executive management, the day-to-day decision making required in a health district. Nuttal argues that clinicians are not suited for executive management since their skills lie in medicine and the fact that individual therapeutic decisions affect management does not justify clinical involvement in the details of management. Clinical priorities are however prior to management priorities and therefore clinicians need to be involved in policy-making. The management team therefore is involved in policy making and not in day-to-day management which is the province of officers.

It has been argued that the spatial location of clinicians is a particular problem for the GP team member since his constituency may be spread over a wide geographical area (Eskin, 1979). The consultant team member may face similar problems if there are a number of peripheral hospitals within the district. Spatial location of constituents may

influence the representative system in a positive or negative way depending upon the nature of the district.[14]

It is important to note that membership of the management team is not the only means by which clinicians participate in management. Clinicians participate through advisory committees, through membership of health authorities and also through the planning system. The clinical team members are also members of the District/Area Medical Committee which may distance the relationship between representative and constituent or clinical colleague. Additionally the representative may be less accessible and less acceptable to those clinical colleagues through this indirect relationship (Brown, 1979). Brown conceptualises this problem as the existence of several layers of representative machinery which also means that the individual clinician may belong to more than one committee resulting in the problem described by Lewis and Weiner,

> Some clinicians have had to decide in each of the forums in which they participate, which side they are actually on and for whom they speak
>
> (Lewis and Weiner, 1975, p.24).

The problem of complexity was also noted by Brown who identified 120 places on the main advisory committees for the doctors in Humberside (Brown, 1979). A consequence of such complexity is that doctors may find it difficult to identify the most appropriate way of dealing with an issue which relates to the management of a service. Alternatively they may deliberately 'bypass' the standard mechanisms of participation in order to achieve their objectives more efficiently.

Studies of the activity of clinical members of management teams have been limited to two postal surveys. The first conducted by Mason in 1976 was concerned with the extent of the commitment made by consultant team

members and the activities which were reduced as a consequence (Mason, 1976). The second study was conducted by Page and included GP and consultant members in the West Midlands Region (Page, 1981). Both studies emphasise the extent of the commitment required of team members in terms of attendance at meetings and other responsibilities. Page points to the lack of appreciation by clinicians and team members of the potential of the representative role. Several findings from both studies are included alongside the results of the empirical research (see chapters 5 - 11).

There is little information in this literature which directly addresses the problems of this thesis. In much of the discussion of this section, reference to the clinical team members is only a marginal aspect of discussions of health service organisation or the reorganisation of the NHS in 1974. The next chapter is concerned with discussing the main hypotheses of the study and the methods used to address them.

CHAPTER FOUR

THE EMPIRICAL STUDY - HYPOTHESES AND METHODS

Introduction

This chapter is divided into two sections. The first concerns the hypotheses which are derived from the preceding three chapters and the second describes the research methods used in the study. The hypotheses centre on the three themes discussed in the first three chapters; the process of representation; the function of co-optation within a complex organisation; and the achievements of co-optation as part of the strategy of the 1974 reorganisation of the NHS.

PART I - The Main Hypotheses

4.1 The hypotheses which follow are ordered around three headings: the process of representation, the function of co-optation within the complex organisation, and the achievements of co-optation as part of the 1974 reorganisation of the NHS. These headings follow the main theme of the first three chapters and also the three main sections of the concluding chapter.

4.1.1 The Process of Representation

The terms representation and co-optation refer to the same process viewed from different contexts. In the discussion of the complex organisation co-optation was designed to deal with some of the problems arising from the existence of several coherent occupational ideologies.[1] For an occupational group or profession, representation is the means of participation in policy-making by which an individual is authorised to act on behalf of the group. This section concentrates on the process of representation while the rest examines the organisational consequences of what is essentially the same problem.

The first hypothesis is the key to this section and the subsequent hypotheses draw upon its component parts:

(a) The outcome of representative mechanisms will depend upon the ability of the representative, the behaviour of constituents as individuals and in groups, and structural factors which affect both representative and constituent.[2]

The outcome of a process can only be properly assessed in terms of the objectives, shared or conflicting, which the actors attribute to it. It cannot be assumed that the clinical representatives co-opted to a corporate management team share the same objectives of participation nor that they have the same views as those they 'represent'. Specialisation and functional divisions within the profession may be important determinants of interests and therefore objectives. Additionally, participants may have only very loosely defined objectives which hinders the examination of outputs. Finally actors' subjective goals may appear to bear little relationship to their activities: at least to the observer.[3]

The first element hypothesised as contributing to the outcome of the representation system was representative ability. This includes a number of factors including expertise - both professional and administrative, personal charisma and aspects of motivation. It is not reasonable to assume that those skills which make up professional competence in medical practice will necessarily ensure an effective representative. Such skills may contribute to the phenomenon of charisma which may only be recognised by specific audiences in particular contexts. The representative does not possess administrative authority therefore any persuasive influence he is able to wield depends on his credibility to his colleagues on the one hand, and the other members of the corporate executive. The representative's credibility to his colleagues will depend to a considerable extent on his

seniority as a doctor and their estimate of his judgement. It was argued in the Grey Book that the representative would need sufficient determination to carry out the job and there is also evidence to suggest that the financial inducement is too low to act as a real incentive (DHSS, 1972a, Jenkins, 1982).[4]

The next item in the main hypothesis was the role of the constituents, both as individuals and in groups. Therefore hypothesis (b) expands upon hypothesis (a).

(b) The commitment of the constituent and constituency to the representative process will depend upon the extent to which it is consistent with important ideas that constitute medical/occupational ideology.

In the reorganised NHS the form of the representative system was largely imposed from the centre after negotiations with representatives of the profession at the national level. This did not assure that the system would be acceptable at the local level in each district. In consequence two main factors affect the acceptability of the representative system in each district: ideological factors and pragmatic factors or experience of the effects of the system in practice. The representative system is based upon ideological presuppositions about the appropriate way of organising medical work. Two central ideas are the concept of clinical autonomy and the related but distinct concept of unmanaged status which are widely recognised among the profession. To the extent that the representative system infringes these 'beliefs' it is likely to be unpopular amongst doctors. Additionally if the representative system is unwieldy or ineffective in practice it may lose the support of the doctors who are supposed to be represented.

One measure of the level of commitment amongst doctors to the representative system is the level of participation in advisory and

representative capacities. Such participation might range from voting in elections - or even holding elections - to participation in committees or taking the role of clinical member of the management team.[5] Participation is inevitably costly since it has an opportunity-cost in terms of time and possibly money as well. While the degree of knowledge a constituent has may constrain his participation within the representative system, it may also be a sign of his commitment to it.[6] The next hypothesis concerns the idea of commitment.

(c) Constituents act instrumentally and so their commitment to the representative system will depend upon their knowledge of its structure and operation, their evaluation of its past performance, and their expectations of its future performance. It is not important whether constituents conceive of the benefits to be obtained through the representative system in material or normative terms, and it is likely that they may have expectations in both categories.

The representative machinery assumes that constituents have the same interests, at least within the functional groupings, by virtue of their shared geographical location which implies that they face the same problems with similar resources. Accordingly doctors in different districts face different problems, have access to different levels and types of resources and therefore require a separate representative system. It is therefore important that the nature of the constituency and its interests should be examined in greater detail. To what extent do the interests of the constituents coincide with the interests of patients or the interests of the community and their health. The interests of the community were to be safeguarded by the health authority and the Community Health Council, and since 1982 the creation of lay authorities in the Districts has, in principle, enlarged the scope for the influence of local interests in the

provision of health services. It is likely that the representative will justify his actions, if called upon to do so, in terms of the benefits of policies to patients although the 'service ideal' has been recognised as an important element of professional ideology.

The next hypothesis concerns the nature of the constituency and its constituents. General practice is undertaken by independent practitioners, usually operating in partnerships, who constitute separate units operating throughout the district. They are dependent upon other services provided in the district - hospital, clinic, diagnostic, nursing services - and therefore share in relationships of dependency and have similar interests although they are seldom dependent upon each other apart from within the partnership. Thus the next hypothesis is that,

(d) The outcome of the representative system for the constituent or the constituency will depend upon the degree of homogeneity or heterogeneity of constituents and their interests.[7]

In the case of a homogenous constituency interests are likely to be shared and so more easily recognised and pursued. The representative is likely to share and be clear of the expectations his colleagues hold of him. If the constituency is relatively heterogeneous,constituents may not share the same interests and it is more difficult for the representative to recognise those interests. The expectations which are held of him may vary in which case the representative is subject to different, competing or conflicting expectations and must choose between them. Where there are no clear expectations, for instance in a heterogeneous constituency, the representative may find he has the freedom to manoeuvre and a degree of autonomy.

The influence of structural factors as a source of heterogeneous interests within the district or constituency has been alluded to in the discussion of interests and expectations. It is therefore hypothesised that,

(e) Both the representative and the constituent are subject to structural and environmental factors which affect the process of representation and the relationship between the representative, his constituents, and groups of constituents.

These structural factors refer to the pattern of organisation of work and the nature, availability, and distribution of resources with which work is performed. The organisation of constituents, for instance in various medical advisory and professional committees, produces important channels of communication through which the representative-constituent relationship largely takes place. Such factors affect the degree of visibility within the representative system, the extent of knowledge among constituents about the system, and detailed knowledge about the timing of decision-making processes particularly where there are formal timetables to be followed. The representative, who occupies a different structural position than that of his colleagues, needs to obtain knowledge of the effects of structural factors on the representative system and such knowledge may form a valuable basis of power.[8]

The next hypothesis concerns the role of the clinical member of the management team who stands at the interface of administration and profession,

(f) The representative's position, as a member of the profession and an equal member of the management team, makes him a focus for competing expectations which arise from a clash of two principles resulting in the necessity for co-optation and representation systems. He is therefore

subject to competing expectations and may experience role-strain.

Both profession and organisation have, and recognise, interests and objectives in the process of representation/co-optation. Members of the profession vary in the importance they attach to the representation process and therefore in their significance as role-senders. The clinical team member must respond in some way to these expectations and the next expectation concerns this response,

(g) The representative is likely to act to reduce role-strain, which may result from competing expectations, as far as possible. He is likely to act in accordance with those expectations where the sender(s) can marshal powerful resources, ideological or material, to enforce their expectations at the expense of other expectations where these resources are not available.

It should also be noted that there are mechanisms open to the clinical team member for defusing or avoiding having to deal with conflicting expectations[9]. He may call a meeting of the appropriate advisory committee or undertake some other form of consultation. This strategy, if used to excess, may weaken the representative's authority in the eyes of his colleagues. Additionally the representative may be shielded from conflicting expectations by the structural and environmental factors referred to above.

4.1.2 Co-optation within the Complex Organisation

The 'theory' of co-optation needs to be examined critically since it was formulated on the basis of a case study and there is little evidence to suggest those conditions where it is likely to be successful or to fail. Therefore this section commences with a restatement of the basic hypothesis,

(a) By co-opting threatening groups into the leadership organisations can avert threats to their stability.

This statement is bland in its assertion and therefore it is necessary to examine the form of the threat, the form of co-optation adopted and the nature of the organisation and its leadership. It was argued in section 1.5 that the organisational forms adopted by professionals working in a complex organisation posed threats to that organisation's leadership sufficiently serious to warrant action which might involve the sharing of power to determine policy. The objectives of the organisation may concern regaining control in the setting of objectives and their implementation. It is misleading to suggest that control is won or lost in any absolute sense since the complex organisation is characterised by a competition for certain sorts of power at various levels within the organisation. Thus, there is a situation where there are a large number of power relationships at different levels within the organisation.[10] The following hypothesis concerns those factors which affect the outcome of co-optation in a complex organisation,

(b) The outcome of a co-optation strategy depends upon the form of co-optation undertaken, the nature of the complex organisation and its constituent occupational groups, and the effects of environmental and structural influences.

The co-optation strategy needs to be acceptable to the leadership of the organisation as well as the profession. Thus at the district level of the NHS the profession is co-opted through GP and consultant who represent two branches of the profession. Representation is equal and co-optation has the aim of integrating local health services as well as preventing the realisation of a threat to the leadership.

Another aspect of the form of co-optation undertaken concerns the patterns of authority and leadership within the organisation. In the NHS, as in many complex organisations, leadership is disjointed and so the form of co-optation has to contend with it. For instance, doctors are co-opted into NHS administration through advisory committees, management teams and health authority membership. This thesis is concerned with local management in the NHS where doctors are 'co-opted' onto a management team which is responsible collectively to a health authority. Therefore the outcome of the co-optation is largely dependent upon the other elements of the disjointed management structure.

The next element in the hypothesis concerns the form of co-optation which is adopted. Selznick pointed to formal and informal categories indicating that formal co-optation may constitute a form of 'tokenism' while power would be shared more effectively in informal co-optation. Undoubtedly the form of co-optation adopted in the NHS is formal but there are other influences on the form of co-optation such as the need for various forms of accountability characteristic of public organisations. The form of co-optation adopted depends upon the reasons for its implementation as in the following hypothesis.

(c) The form of co-optation strategy adopted will depend upon the extent to which the leadership felt its objectives were threatened by professional groups and also by the precise nature of that threat.[11]

A substantial threat may require that co-optation takes place at more than one administrative level and in more than one form within the organisation. A new policy development may require co-optation as a means of securing co-operation necessary to achieve the desired objectives. For instance, the significance of co-optation as a means of achieving the goals of reorganisation in the NHS will be discussed in the next section.

It follows that the outcome of a co-optation strategy may be examined in the negative sense of the extent to which threats to the leadership are ameliorated and in the positive sense of the extent to which it fosters new policy developments.

The form of co-optation strategy adopted in the NHS recognised the nature and organisation of the medical profession and the division of work among it according to function. GPs and consultants were separately represented and the requirement of consensus gives each representative effective power of veto. This form of power would be expected to be less important than other bases of power for the clinical team member.

The next element of the hypothesis concerns the importance of the structure and ideology of the occupational groups co-opted into the leadership. Thus the hypothesis

(d) Co-optation of powerful professional groups onto the corporate leadership may result in the sharing of policy making but persisting failure to ensure implementation due to the nature of authority in professional groups.

Thus the corporate leadership cannot expect to exercise administrative authority to ensure the implementation of policy. It may be able to rely upon the persuasive powers of the clinical members on some occasions but may be restricted to policies which are likely to be acceptable to the professional groups concerned. Consequently decision-making strategies of an incremental nature which recognise the political realities of the organisation may be more effective than rational schemes which are not acceptable to important members and therefore not implemented.

In complex organisations which are state financed and subject to some degree of political control the outcome of the co-optation strategy will depend upon the effect of political decisions which affect the resources available to the organisation. It is likely that changes in levels of resources will be more important than attempts to implement certain policies with respect to the ways in which resources are used at the local level.

4.1.3 Co-optation within the Reorganised N.H.S.

The strategy of co-optation was an essential element within the structure of the NHS since it was important to ensure that policies could be determined and implemented notwithstanding the question of clinical autonomy. Advanced specialisation within the profession resulted in fragmented service provision and integration of service planning and delivery was the first goal of reorganisation. The first hypothesis concerns the effect of co-optation on the policy goal of integration,

(a) The outcome of the co-optation process will affect the policy goal of integration of service planning and delivery at the local level. The goal of co-optation is to provide a framework within which decisions can be made jointly by professional and administrative interests which can be implemented by the organisation. Consensus is not unanimous agreement but indicates that the decision or policy is minimally acceptable to all concerned. For political reasons it may be desirable to accept certain decisions which are in the nature of compromises if they help in achieving other, more important, objectives.[12]

Another goal of reorganisation was to ensure effective leadership at the lowest level at which comprehensive, integrated services can be provided. Effective leadership was conceived within a rationalist framework in which needs were identified, priorities assigned, and services planned

and delivered to meet those needs. The corporate executive was required to decide and implement policies with the important caveat that it could not enforce policies upon clinicians against their will. Therefore the next hypothesis follows,

(b) To determine and implement policy in a complex organisation the leadership will either have to find a means of achieving agreed policies or a source of authority by which they can ensure that the policy is implemented by those who do not share its goals.

One method by which the NHS has attempted to achieve agreed policies is through the systems of medical advisory committees. The 1974 reorganisation of the NHS forged an explicit link between the local advisory committee and the corporate management team through the GP and consultant team members. The local advisory committee was concerned with the execution as well as the creation of realistic policies and therefore the degree to which the District or Area Medical Committee is regarded as a legitimate representative body is, potentially, an important link in the chain of policy implementation. The independent contractor status of GPs, whose contracts are held by the Family Practitioner Committee and who see the Local Medical Committee as their natural constituent body, is a factor which complicates the role of the advisory system particularly in the multi-district area where there was the possibility of 'bypassing' the district level of administration and going direct to the area level. The District or Area Medical Committee was composed of representatives of the three main functional branches of the profession and therefore needed some means of dealing with disagreements between intra-professional groups. Equal membership between the three branches was designed to ensure that no section had a majority of members and therefore numerical advantage in the decision-making process.[13]

An assumption which permeated the decision-making literature was that the 'needs' of one district could be distinctly different from those of another, perhaps neighbouring, district and needed to be managed separately. Consequently local clinicians needed to be co-opted onto the executive to take account of local needs. This assumption gives rise to the following hypothesis.

(c) Co-optation at the local level enables policy-makers to take account of local needs which are assumed to differ from the needs of other localities.

It is assumed that clinicians will share interests because of their geographical location and access to services which to some extent outweigh their sectional interests. It is crucially important that structural integration was not achieved in 1974 or in 1982 and this ensures that GPs will pursue sectional interests through the Local Medical Committee (LMC) and the General Medical Services Committee (GMSC). Additionally, significant decisions concerning revenue, capital and manpower resources are made at the Regional level and the local management team have only limited influence. The next hypothesis concerns the structural nature of the NHS,

(d) Disjointed policy-making structures in the NHS act against the success of co-optation mechanisms in achieving integrated leadership at the local level.

Hypothesis (b) emphasised that effective leadership requires that a degree of compliance is necessary from those who deliver services within a district. The policy-documents concerning reorganisation indicated that medical representatives needed to be experienced clinicians who could predict the likely response of their colleagues to policy options. It was argued above that the clinical member of the management team would require other skills to fulfil his role, hence the hypothesis,

(e) The possession of clinical skills by the medical representative does not necessarily imply that he will also possess the skills or knowledge needed by an effective manager.[14]

It follows that the clinician is likely to be uninformed about many of the issues and processes of local management in the NHS which are the skills of administrators. The team must therefore be able to reconcile members who usually work according to different principles. Thus the administrators must recognise that they need the co-operation of other members of the team and the clinicians must recognise the influence of administrative principles of work.

4.2 PART II - The Empirical Study

The objectives of the empirical investigation were two-fold: to gather basic information about the system of co-optation adopted at the local level in the NHS; and to test hypotheses about the process of representation in the NHS, the function of co-optation within a complex organisation, and the function of co-optation in relation to the 1974 reorganisation of the NHS. The methods used are discussed below in relation to these objectives.

4.2.1 Collection of Basic Information

There has been no investigation, on a national scale, which examined the effectiveness of the co-optation strategy involved in the 1974 reorganisation of the NHS. Information, even of the most basic nature, is scarce and has been collected for particularly limited purposes (BMA, 1977; Mason, 1976; Jenkins, 1982). It was not possible to make authoritative judgements about the hypotheses outlined above from the largely subjective reports in the professional literature and so an investigation was conducted using three complementary methods.[15] A search of the professional and official

literature was undertaken, semi-structured interviews were undertaken with doctors and members of health authorities, and a series of surveys were conducted among members of the GP representative's role set. The combination of methods followed the principles outlined by Denzin in his discussion of the empirical methods most relevant to interaction theory in which he argues,

> ... multiple methods must be used in every investigation, since no method is ever free of rival causal factors (and thus seldom leads to completely sound causal propositions), can ever completely satisfy the demands of interaction theory, or can ever completely reveal all the relevant features of empirical reality necessary for a theory's test or development.
>
> (Denzin, 1970, p.26).

This claim errs towards extremism since it is doubtful that any combination of methods ever reveals all the relevant features of 'empirical reality', which is itself socially defined, but it is reasonable to argue that multiple methods avoid some of the shortcomings of single methods, particularly in studies where an important element is interaction within a role-set.

The NHS exhibits a wide degree of variation between districts and areas due to the differing heritage of capital resources and services, and to a lesser extent to the differing traditions of management and the organisation of medical work. It is therefore important to have basic information on the range of variation between health districts and single-district areas and the variations in their implementation of the relevant elements of the framework for management of the reorganised NHS.

The Process of Representation

The examination of the hypotheses in this section rests heavily upon the basic information concerning the structure of the representative and advisory mechanisms and the behaviour of the actors involved. There was a

certain amount of information about particular districts or areas in the professional and academic literature but the main sources of information were the questionnaire survey, the semi-structured interviews and conversations with members of management teams and doctors. The interview data tends to be highly specific and related to particular districts and examples while the survey data gives more general information and highlights trends among districts. From the survey data it is possible to associate the elements of the representative process with structural factors in an attempt to observe correlations between structural influences, such as the distinctive form of organisation in single-district areas, and important elements of social behaviour in the representative process.

Representation within a Complex Organisation

This series of hypotheses is examined using survey data and interviews concerning the determination of policies and their implementation by doctors. The survey was used to obtain information about the processes by which policies are determined by the management team, the content of those policies, and the means used to ensure implementation of those policies which require the compliance of doctors. Information was obtained about the means of decision-making (or non-decision-making) in the case of contentious issues and the methods used to prevent conflicts from becoming apparent. Since these questions are largely dependent upon the responses to the survey, they are supplemented as far as possible by the interview findings. The survey is also an important source of information concerning the means of communication between members of the GP team member's role-set.

Co-optation in the Reorganised NHS

The review of literature - academic, professional and official - formed the essential first step in identifying the policy objectives of

reorganisation. These objectives were examined at the levels of formal objectives specifically stated in documents, and also other objectives were identified by the researcher through critical examination of the range of policy-decisions, their implications, and hence their probable purposes. The extent to which co-optation at the local level has assisted in the pursuit of these objectives was then discussed in the light of data from the survey and interviews.

4.2.2 The Analysis of Literature

A number of discrete types of literature were examined in the development of the hypotheses and also in their testing. The official literature produced by government departments, or groups specifically set up by these departments to examine the involvement of doctors in the management of the health service, was examined to discover general policies concerning the involvement of doctors in management and also the specific objectives of the 1974 reorganisation of the NHS. These documents offered possible explanations for the failure of the NHS to achieve certain objectives and implied other problems through the analysis offered and the solutions proposed.[16] For instance, the Grey Book achieved the status of a structural blueprint and implied a theory about the nature of complex organisations and the most appropriate management arrangements.

The professional literature included writings by both doctors and officers of health authorities concerning the impact of co-optation strategies in particular localities.[17] This literature was largely subjective in nature and local in its application yet it represented the views of some participants. It also provided clues to the ideological significance of aspects of the representation-co-optation process.

The third category of literature came from the academic community and tended to address wider questions than the subject of this thesis. For instance Brown's study of Humberside was concerned with the impact of reorganisation but included analysis of the representative and advisory systems (Brown, 1979, chapter 7). Additional literature provided evidence upon the ways in which services were managed and resources distributed which provided important contextual data in which the findings of this study could be evaluated.

4.2.3 The National Survey

The method chosen to conduct the survey needed to fulfil a number of important criteria. Firstly it was necessary to provide results from which generalisations could be made in which the idiosyncracies of particular authorities or individuals were viewed in a wider context. Variations between authorities resulted from the historic inheritance of resources as well as decisions concerning structural relationships between districts and areas made by the Secretary of State in 1973-74. Secondly, the method needed to be wide-ranging and to submit to the constraints of a single researcher with limited finances. These two criteria ruled out an interview survey and indicated a postal survey. Most importantly, the method needed to ensure that the research hypotheses could be tested and this is discussed in more depth below.

The Postal Survey

The National survey was adapted to fulfil the criteria outlined above. It offered a number of advantages to the researcher. It could be piloted and administered in a comparatively short time and at modest cost when compared with an interview survey. It dispensed with the problem of interviewers to be trained, monitored, and accounted for in assessing the results. Each respondent was faced with exactly the same

questions and so in this sense the results were comparable. This did not mean that the choice of wording of questions was a matter for complacency but this problem affects most social science research in one guise or another.

The first problem of the postal survey is non-response. The decision as to what constituted an acceptable level of response was necessarily arbitrary and it was difficult to assess the effect of non-response on the findings of the study. Answers to these questions depend upon the degree of variation between the sample being interrogated, the degree of variation in the population and the means by which the sample was drawn. It is normal practice to assume that some degree of non-response is inevitable and then to compare respondents and non-respondents to try and assess the significance of that non-response.

As important as the problem of non-response is the limitation a postal questionnaire places upon the quality of data which can be obtained. The postal survey is best suited to subjects in which there are no substantial areas of ambiguity. It is more difficult to deal with more complex ideas since there is no opportunity to probe answers that are unclear or inadequate. The question of coding is entirely dependent upon the nature of answers required which may enable pre-coding of questions with a limited range of possible answers but more sophisticated coding strategies for the responses to open questions.

The Choice of Respondents

Respondent categories were chosen in line with the objectives of the study namely; examining the process of representation, the function of co-optation within the complex organisation, and the function of co-optation as a means towards the objectives of reorganisation in the NHS. As the central focus of the study the GP member of the management team was

inevitably selected but it was necessary to identify the members of the role set. A series of criteria were drawn up in the light of the preceding hypotheses to identify the appropriate respondents.

(a) Respondents were chosen who have expectations of the representative or who are in some way dependent upon his performance.

(b) Respondents were chosen whose organisational position enabled them to observe the performance of the GP member of the management team.

(c) Respondents were chosen who could observe the creation of expectations through the medical and professional advisory machinery.

Using these criteria the categories of respondent chosen were practising GPs, secretaries of District or Area Medical Committees, secretaries of Local Medical Committees, District and Area Administrators, and GP members of management teams. Since this was a vital methodological decision, the justification for these choices is discussed below.

The Practising General Practitioners

The GP member of the management team was selected as a representative of the GPs working in his district or area. It follows from the arguments put forward in the Grey Book that they have - at least in principle, an interest in his performance as representative and as 'manager'. The extent of this interest, which was predicted to depend upon a number of factors discussed in section 4.1.1, is a matter for empirical answer.

This 'interest' may or may not be translated into expectations which are 'sent' to the GP team member. To some extent, since he is also a GP working in the district, the GP team member will share the interests of other practising GPs within the district. The practising GPs' organisational position is such that they may be able to observe some aspects of

the GP representative/team member's performance in that role. For instance, they should be able to observe whether the GP team member consults them or attempts to persuade them to support district or area policies. The practising GPs are members of, or represented by, other advisory and professional committees and able to provide evidence on the expectations which practising GPs have of these committees. Thus the sample of GPs were able to provide evidence on constituent expectations and behaviour, constituent views of the performance of the representative system and the GP team member, and also constituent views of the main advisory and professional committees.

The District or Area Medical Committee Secretaries

The GP team member has to be selected by the District or Area Medical Committee and be to some extent dependent upon and accountable to it. With the consultant team member the GP was supposed to state 'the medical view' if such a view existed or to state whether a particular course of action would be acceptable to the profession locally. The literature sometimes referred to the GP team member as the District or Area Medical Committee representative and therefore the committee were expected to come to agreed policies which would be championed by the GP and consultant team members. The District or Area Medical Committee secretary was selected as the person most able to answer questions on the formulation of policies or expectations by the committee and the performance of the GP team member in response to those expectations.[18]

As the GP team member was also chairman or vice-chairman of the District or Area Medical Committee, the secretary was well able to observe that aspect of the role of the team member. It was argued above that the question of the communication of information was an important aspect of the representative process.[19] The secretary of the District or Area Medical

Committee was in a position where he could observe the communication of information between the committee and GPs practising in the district or area.

The Local Medical Committee Secretary

The Local Medical Committee is the chief professional committee which represents GPs in all matters of mutual interest. Organised to be coterminous with the Family Practitioner Committee - the body which holds GPs' contracts - the Local Medical Committee also has links with the General Medical Services Committee at the national level. To some extent the Local Medical Committee may also act on behalf of GPs within the district and has the facilities to represent GPs since many LMCs have paid secretaries. In the Single-District Area the Local Medical Committee was coterminous with the management team and the Area Medical Committee and therefore able to act as the representative body for GPs.

There is no formal link between the Local Medical Committee and the GP team member in the official reorganisation literature but it became increasingly clear through the pilot study that in some cases the link was very strong. It was expected that the LMC would play some role in the development of expectations amongst GPs, particularly where those expectations were of a nature which concerned GPs in more than one district. Thus, the LMC secretary was selected because of the important role of the LMC in the creation of expectations and as a reference group for GPs.

The District or Area Administrator

The District or Area Administrator was recognised as the member of the management team with responsibility for co-ordinating the activities of the team.[20] For this reason the administrator was the most appropriate respondent from whom to ascertain the expectations the team had of its

clinical members, the procedures by which the team operated, and information about the performance of the GP team member. It was also felt to be important that the administrator, the chief officer of an occupational group who work according to the administrative principle outlined above should be selected since to some extent the nurse and the finance officer are chief officers of specialised functional groups.

The administrator might also be expected to have expectations of the clinical members of the team which resemble those of the officer members.

The Sampling Method

Scotland and Northern Ireland were excluded from the study since, although they have forms of co-optation, there are significant differences in management structure which prevent simple comparability. The 1979 Hospital and Health Services Yearbook (HHSY) listed 221 districts or single-district areas (SDAs) in England and Wales which formed the basic sampling frame. The management structures in health districts and single-district areas was similar to the extent that both had management teams with the same composition and relationship to the main district or area advisory committee. The difference lay in the relationship to the Area Health Authority, Family Practitioner Committee, and Local Medical Committee which was direct in the single-district area and indirect in the health district. The direct relationship indicates a one-to-one coterminous relationship while the indirect version indicates that the district is only one of two or more districts that relate to the authority or committee.

This structural difference was of significance since at the outset of the study there were those who felt that the single-district Area represented the most efficient structural form, and as the study progressed it was announced that the SDA would form the model of the post 1982 service.[21]

Since there was no single listing on which all five groups of respondents appeared, it was necessary to use the Medical Directory for drawing the sample of practising GPs and a listing of Local Medical Committee secretaries obtained from the Kent Local Medical Committee.[22] The advantages and disadvantages of the three sampling frames need to be discussed in some detail since they were an important constraint upon the study.

The Hospital and Health Services Yearbook (HHSY) formed the basis for three of the five surveys; the District/Area Administrator, the GP team member, and the District or Area Medical Committee Secretary. The first problem concerned the inevitable delay in publication which means that some entries are out of date by the time of publication. In this study the HHSY 1979 was used and there had been a structural change in which two districts had amalgamated resulting in the loss of one district completely. The HHSY listed the names of the District/Area Administrator and also the GP team member and publication delays meant that a small proportion of the positions had different occupants. These problems were relatively easy to overcome once they were discovered and did not seriously affect the study.

The Medical Directory was used as the sampling frame for practising GPs since it was the only publicly available listing from which a national sample of GPs could be drawn. The Medical Directory was not restricted to the names of GPs and the listing was not complete since it was dependent on doctors sending in a personal entry. It was therefore necessary to devise criteria by which to identify GPs from the entries in the directory. These criteria are listed below:-

(a) The doctor's qualifications and membership of learned societies and Royal Colleges.

(b) Details of partnership arrangements or surgery addresses.

(c) Details of the doctor's previous career and publications.

(d) The doctor's age since the directory included practitioners who had retired.[23]

The investigator made a judgement from using these criteria as to whether an individual entry referred to a GP or another specialist. The criteria were used to include and exclude since some doctors had qualifications that indicated a hospital specialty and also details of a hospital appointment which suggested exclusion. Membership of the Royal College of General Practitioners indicated that the respondent was a GP but other collaboration was sought using the above criteria.

As a sampling frame the Medical Directory was far from ideal but the sample can be assessed to a limited extent by making comparisons with the population of GPs where there is the appropriate information. Finally the listing of secretaries of LMCs was complete and there was no sampling since there were only 98 LMCs.

Drawing the Sample

For each survey (except the Local Medical Committee where a census was conducted) the sample was selected independently from the appropriate sampling frame using random number tables (see Table 4.1). It follows that each survey is logically independent since the sampling unit was the individual GP, District or Area Administrator, District or Area Medical Committee Secretary or LMC Secretary. It was coincidental if each of the surveys included in its sample a member from one particular district. The underlying intention was to ensure that respondents did not feel they were being asked to comment on the performance of a named individual since the study was concerned with the position and its significance in relation to an organisational strategy.

The sample of GPs is also independent since it was not possible, or

desirable, to assign them to a particular district. A GP's list does not have clearly defined geographical boundaries and may cross one or more district boundaries. For instance, one respondent had patients who lived in Scotland although his surgery was located in England.

The main samples of 100 GP team-members, District or Area Administrators and District or Area Medical Committee secretaries were drawn independently from the Hospital and Health Services Year Book and a further 20 were drawn for the purposes of piloting. The pilot samples were drawn after the main sample since with a small population and a relatively high sampling fraction the risks of contamination were high. The main sample of 200 practising GPs was drawn from the Medical Directory by random numbers to identify a page number and then using the criteria outlined above to select the first GP listed on that page. Again 30 pilot cases were chosen after the main sample. Since response rates to practising GPs tend to be lower than to the other groups of respondents a higher sampling number was chosen although the sampling fraction was very low - about 1/110

The sampling fractions for the GP team members, the Administrators, and the District or Area Medical Committee secretaries were sufficiently high to suggest, with a reasonable response rate, that the replies would be representative of the population. In the case of the practising GPs the sampling fraction was very low and so the findings would be of questionable significance.

The Pilot Surveys

The chief objectives of the pilot surveys were as follows;

(a) To test the adequacy of the sampling frames.

(b) to discover the degree of variability among the respective populations in regard to the subject of the study.

(c) To give some idea of the likely response rates and the associated problem of non-response.

(d) To test the suitability of the postal questionnaire as a means of collecting suitable data.

(e) To test the adequacy of the questionnaires as research instruments.

(f) To examine the efficiency of the instructions on the questionnaire especially where there were logical relationships between questions.

(g) To assist in the assessment of pre-coded questions and the coding of questions in the analysis of the main survey.

(h) To test the procedure for managing the surveys.

The first objective could only be partially achieved since the size of the pilot survey was necessarily small. The response rates to the GP team member, Administrator, and District or Area Medical Committee secretary surveys was sufficient to suggest that the Hospital and Health Services Yearbook was satisfactory; especially since there were no reminders sent at this stage. The response from the sample of practising GPs was relatively poor suggesting that the sampling frame (The Medical Directory) and the method of drawing the sample might be suspect. Since, however, there was no alternative this deficiency had to be accepted.

With respect to the second objective, the pilot survey indicated a good deal of variation between the surveys in the respondents' knowledge of the representative and management process. The practising GPs showed relatively little knowledge, with some notable exceptions, about the representative system and some demonstrated a degree of hostility - whether this was aimed at the topic or the investigator was a matter for conjecture. Many GPs saw little relationship between their work with patients and the management of district or area services. Modifications were made to the questionnaire where it was obvious that questions failed to obtain the desired range of responses or where the pre-coded categories were irrelevant.

The pilot surveys demonstrated that an adequate response rate was possible in each survey with the possible exception of the practising GPs. Their response was regarded as vital and therefore it was decided to use two reminders in the main survey in an attempt to boost the response.

It was argued above that one of the characteristic difficulties with postal questionnaires is the limitations they place upon the data which can be obtained. The number of open questions was kept to a minimum since there was evidence to suggest that such questions were more demanding of the respondent and in many cases did not yield the desired information. The answers to each question were carefully examined to ensure that the respondent understood the question and answered it adequately. This resulted in minor changes in the wording of questions and instructions and adjustments in the layout of the questionnaires.

Detailed coding frames were produced for each survey based largely upon the results of the pilot survey and these were valuable in the analysis of the main surveys.

The pilot survey tested out the procedures to be used in managing the main survey. Each mailing contained a business reply-paid envelope addressed to the investigator and two letters, one from the investigator and one from the Assistant Director of the Health Services Research Unit, explaining the purpose of the study and form of assistance required from the respondent. Evidence suggests that the use of personal letters and pre-paid envelopes may encourage a higher response rate.

Analysis of the pilot surveys was conducted by hand since the size of the data-set did not warrant computer facilities which might require considerable adjustment before the main survey.

The Main Surveys

An identical procedure was carried out in the main surveys to that in the pilot stage with the addition that two reminders were sent to those who had not responded after two weeks and after six weeks. The first reminder consisted of a letter from the researcher and the second reminder included a duplicate questionnaire (see appendix 1). Table 4.2 shows the number of responses to the questionnaire immediately, after the first reminder, and after the second reminder. These figures do not prove that the reminders necessarily increased the overall response rate although the response rates were higher in each case than in the pilot survey. In the GP survey there was an apparent improvement in the main survey over the pilot survey and the reminders also elicited replies from GPs who had ceased to practice and were therefore inappropriately drawn in the sample. It is however possible that the reminders increased the speed with which respondents returned the questionnaires in each of the surveys.

The dates of the mailings of surveys and the reminders are shown in Table 4.3. The Local Medical Committee Secretary survey was carried out one year after the other four surveys since it was apparent from the main surveys that the LMC played an important part in the creation of expectations and the representation process.

Response Rates

The response rates to the pilot and main surveys are shown in table 4.4 The sample figure is divided by the response and the answer expressed as a percentage. The procedure for the sample of practising GPs was to remove those GPs who were retired or had died from the denominator (sample size) and divide the remainder by the number of respondents. Thus, the percentage gives the number of respondents from those GPs who fall in the intended sample.

The information about the non-respondents in each survey is limited and obtained in many cases from correspondence 'provoked' by the two reminders. In the case of the administrators, one non-response resulted from a refusal, two from structural changes, and one from a vacant post. In the District or Area Medical Committee Secretary survey five cases were identified where the committee had ceased to exist and so there was no response. The GP team-member non-response included at least one district where there was no incumbent at the time of the survey.

4.2.4 The Semi-Structured Interviews

Interviews were conducted with members of the GP team member's role-set to supplement the information obtained from the existing literature and also from the surveys. These 'interviews' included tape-recorded interviews with members of the role-set using a check-list of topics around which the investigator phrased his questions, as well as many conversations with respondents individually and in groups which took place in a wide variety of settings.

Informal interviewing may range from the 'non-directive' or biographical approach (Terkel, 1975; Johnson, 1976) to the focussed interview in which the interviewer uses an aide memoire with which to structure the interview allowing the systematic probing of questions with which the investigator is particularly concerned (Hunter, 1980, p.70). In this study the interviews ranged from non-directive discussions to interviews in which a clearly defined set of issues was raised by the interviewer. The interviewing was seen as a means to clarify the process of moving from individual, discrete observations to distinguishing patterns of behaviour in the sense of 'grounded theory' (Glaser and Strauss, 1967). The difficulties experienced with this form of interviewing were that the interviewer needed to be sensitive to the implications of the questions being discussed

since they involved matters concerning the respondent's relationship with other members of his profession and the role-set upon which he was dependent. The problem of interviewer bias is increased since there are no structural guidelines or preset questions. One means of attempting to deal with this issue was to tape-record interviews and then analyse the interrogator's questions and responses as well as the responses of the respondent.

At least three main questions were considered in the planning and conduct of the interviews. Firstly, does the respondent have the necessary information and does he recognise the concepts and structures which the researcher is using? It was clear that many practising GPs did not recognise any interests to be achieved by GP membership of the management team. As a finding, this was interesting since it opposed many of the conventional assumptions underlying policies of co-optation and representation, it did not however make for easy interviews. Additionally it was possible to seek a degree of reflexivity from the GP team member which was unnatural, in which case the interview consisted of constructive thinking about an issue rather than the respondent relating known facts or existing opinions. Secondly it was important to ensure that the respondent understood the nature of the interview and the kinds of responses which were helpful and those which were irrelevant or tangential to the subject under consideration. Lastly it was important that the respondent was sufficiently motivated to take part in an interview which was potentially time-consuming and complex.

Five forms of inadequate response have been identified in the literature (Kahn and Connell, 1957). Partial response refers to answers which the interviewer feels are incomplete. Non-response is an obvious problem but irrelevant response may be more difficult if the respondent does not wish to answer a question or feels that his response is appropriate. Inaccurate response may or may not be recognised by the interviewer or the

respondent. Finally the respondent may recognise that he is unable to answer the question which is an interesting finding which may indicate unrealistic expectations on the part of the interviewer.

The analysis of data from the informal interviews must recognise a number of problems in dealing with semi-structured interview material. Firstly the responses may not be directly comparable in the same way as answers to a standard question in a structured interview or questionnaire. Therefore results cannot be aggregated in a simple cumulative manner. Secondly, the number of interviews which can be conducted is such that the responses cannot be said to be representative of the category of respondents in the same way as responses from randomly selected samples. Thirdly, the responses frequently give a degree of detail which is not found in the postal survey.

It is for this reason that the use of material from semi-structured interviews must be carefully examined in the light of findings from other areas of the study. The essence of the position taken in this study is that the findings of the semi-structured interviews are questioned and usually discarded if they are not supported from other aspects of the study.

4.2.5 The Analysis of Survey Data

The responses to the postal survey were split into responses to open and closed questions. Responses to closed questions were transferred to coding sheets and cards were punched from these sheets for processing using the Statistical Package for Social Sciences (SPSS). A coding frame was devised to ensure that answers to closed questions were correctly coded. The coding system involved another coder who made an initial coding decision which was checked by the investigator to ensure accuracy and consistency. Additionally range and consistency checks were carried out to ensure the accuracy of coding and card punching.

The analysis of open questions was carried out by the researcher who commenced by listing the responses on large sheets of paper (see Glaser and Strauss, 1967). Unlike the semi-structured interviews the open questions were identical in each case and therefore the investigator's task was dividing the answers into an appropriate taxonomy. Since each answer is unique the assigning of answers to particular categories depends upon the judgement of the investigator. One important factor to remember is that respondents occupied positions in different authorities in which the material circumstances differed and therefore it might be expected that the priorities identified by respondents related to the levels of services in their area. It was assumed that the national survey of randomly selected respondents would compensate for the effect of particular idiosyncratic circumstances.

In coding the questions which concerned matters of opinion, a simple form of content analysis was used. The answers were listed and systematically analysed to find whether certain factors were present or absent. Thus many answers identified a number of priorities which were coded quantitatively. This does not ignore the fact that the answers had an integrity of their own and could be used in a similar way to elements of the semi-structured interviews.

In the text quotations from interviews and responses to survey questions are quoted verbatim. In some cases slight alterations have been made to protect the confidentiality of the respondent concerned. Responses to open questions are referenced according to the appropriate survey number given to the respondent.

Summary

The method of Sociological Research outlined by Denzin includes both theoretical and methodological triangulation.[24] The opening three chapters attempted to combine theories concerning the complex organisation, the behaviour of professional and administrative groups, and theories of representative behaviour with an analysis of the structure and intentions of the reorganisation of the NHS 1974. This chapter has outlined the most important hypotheses and the methods used to examine them. The findings are discussed in the following chapters.

Table 4.1 Sampling Procedure Employed in the National Survey

	GP team members	GPs	DMC/AMC Secretaries	LMC Secretaries	Dist./Area Admin.
Size of Population (England & Wales)	221	22,000	221	98	221
Sampling Frame	Health and Social Service Year Book	Medical Directory	Health and Social Service Year Book	LMC Listing	Health and Social Service Year Book
Sampling Fraction	$^1/_{2.21}$	$^1/_{110}$	$^1/_{2.21}$	$^1/_1$	$^1/_{2.21}$
Number Sampled	100	200	100	98	100
Number Responding	89	133	80	83	96
Response Rate	89%	75%*	80%	85%	96%

*This percentage is calculated excluding those GPs who had died or retired and were therefore inappropriately drawn in the sample.

Table 4.2 Response rates in the main survey by category of reminder

Reminder Category	GP team member	DMC/AMC Secretary	Administrator	GP	LMC Secretary
Immediate	51 (51)	40 (40)	65 (65)	84 (42)	52 (53)
First Reminder	27 (27)	22 (22)	25 (25)	22 (11)	18 (19)
Second Reminder	11 (11)	18 (18)	6 (6)	27 (13)	13 (13)
Non Response	11 (11)	20 (20)	4 (4)	63*(32)	15 (15)
Total Sample	100 (100)	100 (100)	100 (100)	200 (100)	98 (100)

Percentages in brackets total downwards.

Table 4.3 Dates of mailings in the main survey

Respondent	First Mailing	Second Mailing	Third Mailing
GP team member	20.11.79	4.12.79	15. 1.80
Administrator	22.11.79	6.12.79	15. 1.80
DMC/AMC Secretary	16. 1.80	5. 2.80	21. 2.80
GP	18.1.80	8. 2.80	22. 2.80
LMC Secretary	29.4.81	29. 5.81	26. 6.81

Table 4.4 Response rates in main and pilot surveys

Category	Pilot Survey			Main Survey		
	Number	Sample	Percentage	Number	Sample	Percentage
GP team member	17	20	85	89	100	89
District/Area Medical Committee	15	20	75	80	100	80
Administrator	17	20	85	96	100	96
GP	17	30	57	133	200(178)	75*
LMC Secretary	-	-	-	83	98**	85

*22 of the sample drawn from the Medical Directory were no longer in general practice. Eight were practising some other form of medicine, 12 had retired and two were dead.

**The LMC survey was a census of the population of Local Medical Committee Secretaries.

CHAPTER FIVE

THE PROCESS OF REPRESENTATION

5.1 Introduction

This chapter outlines the basic information obtained from the postal survey on the process of representation. The first section concerns the organisation of general practice and the participation of GPs in the professional, advisory and management committees in the NHS. This is followed by a discussion of the evidence concerning the selection of representatives and the significance of the selection process in the legitimation of representative authority. The third section concerns the role of the Local Medical Committee in the legitimation of representative authority and the structural constraints which affect its relationship with local management. The fourth section discusses the activity of District and Area Medical Committees and their effect upon the representative system. In the fifth section the concept of a constituency body (or proxy constituency) is introduced and the model is applied to the District/Area Medical Committee.

5.2 General Practice and the Representative System

The empirical study was restricted to the role of the GP team member and therefore the organisation and structure of general practice forms the starting point for the analysis of the process of representation. The activity of GPs and GP members is constrained by the structure and pattern of work as hypothesised in section 4.1.1 and so a few general comments are necessary on which to base the following discussion.

Unlike the consultant or hospital doctor, the GP is not an employee of the National Health Service and the fact of independent contractor status is central to the GP's self-image. He is nonetheless dependent upon

the NHS for his income and also for many of the resources with which he carries out his work. The budget within which he operates is 'open-ended' although there are mechanisms to control the nature of drugs provided and the total of prescribed drugs and appliances if this is above average. He is also dependent upon budgets held by hospital doctors and administrators if he wishes to take advantage of services provided in the hospital or community by NHS employed staff.

GPs typically practice in partnerships with one or more other GPs and a variety of other staff who may view themselves as a primary health care team. A minority of GPs practice alone or singlehanded and these accounted for 15% of the total in England and Wales in 1979. The remaining GPs (85%) practised in partnerships of two or more doctors at the time of the survey (see Table 5.1). The partnership is widely regarded as the 'ideal' form of professional organisation since it allows a wide range of individual autonomy while allowing partners to share the fixed costs of the business. GPs are in broad agreement about the nature of their work and there are innumerable articles in professional journals explaining how they can maximise their income through efficient organisation, the use of accountants, micro-computers, and other means used by small, and not so small businesses.[1] Repondent H who was part of a large practice in a seaside town commented that the practice created employment for nearly 100 people and that the partnership was probably the biggest business in the town.

The significance of partnership size for the present purpose is its effect on the GPs' ability to manage the demands of work. Since GPs contract to provide 24-hour cover, the single-handed GP is tied to his practice more than a partnership of five doctors where a one in five rota can be operated for out of hours calls. A partnership may provide a degree of flexibility to the individual GP to order his own work and to fit in

with the demands of his colleagues so that each member benefits. Other factors may enable the GP or the practice to order their work to suit their own preferences such as the use of appointments systems, the primary care team, deputising services for out of hours calls or arrangements with other practices to provide cover. Nonetheless the partnership is likely to be an important element in the planning of work by GPs. It is important to note that each partnership is unique since it also implies a range of additional staff, capital and equipment which form the environment in which work can be carried out. These factors affect the sorts of interests which GPs share in respect of the services provided within the other sections of the NHS. Another factor deserves mention although its significance is uncertain, that is the list size (see Butler, 1973, 1980). It appears that it is too simple to assume that list size acts as an independant variable affecting the forms of care which the GP gives but rather that it is one of many factors which affect the content of the GPs' work.

Table 5.1 demonstrates the structure of partnerships in the NHS in England and Wales in 1979. Alongside is the partnership size for the respondents to the surveys of GP team members and practising GPs. The principal finding was that only 2% of GP team members practised single-handed while the corresponding figure for the population of England and Wales was 15%. This finding supports the contention that the demands of a single-handed practice are such as to make it very difficult for the GP to take on additional responsibilities such as membership of a management team. Even if all the non-respondents to the GP team member survey had been single-handed practitioners the response would still have under-represented this group of doctors marginally. Additionally the practising GP survey obtained a response of which 9% were single-handed practitioners suggesting that, although the sampling method was likely to draw a sample which under-represented single-handed GPs, these GPs were not relatively unlikely to respond.

Another explanation for the small number of single-handed GPs among the GP team members response is that the number of GPs in single-handed partnerships has been falling steadily and may represent the traditional end of the spectrum of general practice. Table 5.2 shows that the number of GPs in single-handed practice fell by 820 or 20% between 1971 and 1979 in England and Wales. In contrast the number of practices with four or more doctors is growing rapidly. In 1971 6,339 GPs were working in such practices while in 1979 the corresponding figure had grown to 9,566, an increase of 51%. Thus practices of four or more partners accounted for 30.7% of GPs in 1971 and 42.2% in 1979. During this period the total number of GPs had risen by 2,067, or 10.0%.

Table 5.1 shows that GP team members were relatively more likely to belong to practices of four or more doctors than would be the case if their partnerships reflected the distribution of the population of GPs in England and Wales. This association suggests that GPs in larger practices are more likely to be able to find the time for management activities than are GPs in single-handed practices. The variable partnership size should not be seen as an independant variable unconnected with other aspects of the GPs' views or behaviour. GPs have the opportunity to work in practices of different sizes and, although these choices are constrained by financial and other factors, particular partnership arrangements which may reflect the doctor's attitude towards general practice and the appropriate relationships with others, whether they are doctors, patients or other members of the NHS.

It should not be concluded that GP representatives who work in large partnerships necessarily find it easy to divert sufficient hours of time for team management (Jenkins, 1982; Eskin, 1982). The financial 'reward' is usually regarded as practice income since it is earned by a partner

during working hours and other partners have to cover for him.[2] One respondent commented in some detail about the necessity of ensuring that his obligation to the practice was fulfilled while another noted that a potential GP team member was unable to take up the role since he did not have the support of his partners.

Hypothesis A suggested that the outcome of the representative system depended upon representative ability among other factors.[3] One element of this ability is the question of experience and knowledge of medical advisory, management and professional committees. Both the GP team members and the practising GPs were questioned about their membership, both past and present of these committees, so that the experience of team members could be compared with that of a sample of GPs. These figures also throw some light on the GP team members' interaction with other GPs, his familiarity with their views, and whether these committees act as proxy constituencies.

It was evident from the survey of practising GPs that the majority of doctors who responded did not currently, nor had they previously, belonged to any of the professional, management or advisory committees listed on the questionnaire.[4] Table 5.3 shows that 86% currently belonged to no committee and that 71% had never belonged to any of the committees listed. This suggests that the majority of GPs do not take any part in the advisory or management committee system. There was evidence to suggest that some of the sample of GPs felt that these activities were either peripheral to the work of the GP or harmful since they diverted time from patient care. For instance, respondent 3011 commented,

> ... I have remained totally unconcerned about the administration of our own practice or local medical politics.

Another GP spoke of the significance of the location of his practice but indicated that the care of patients was of priority,

> As a somewhat isolated rural GP, concerned with the care of patients I know little or nothing about District/Area management.
>
> (GP 3140).

A final example was GP 3035 who commented upon the workload of his two doctor practice and then argued,

> I know nothing about the various committees you mention (in fact I hardly know they exist) and if they do send out minutes or information I have no intention of reading any.

These GPs each displayed views in which the significance of patient care explicitly or implicitly were central to their view of general practice and issues of 'administration'or medical politics were irrelevant. Returning to the 18 GPs who were members of committees at the time of the survey, 9 belonged to one committee and 9 to two or more committees (Table 5.3). Additionally 32 GPs had previously belonged to one committee and 6 to two committees. Thus while membership of professional, advisory or management committees was a minority activity, those GPs who belonged to one committee were likely to join other committees thus increasing the workload.

Table 5.4 concerns the small proportion of the practising GPs who belonged to any particular committee. The Local Medical Committee was the most important accounting for 7.5% of the respondents reporting current membership, while 6.7% belonged to a Health Care Planning Team and 5.2% to the District or Area Medical Committee. Taking the figures for present and past membership together, 23% of the sample were either currently or had previously been members of the Local Medical Committee which was twice as many as the corresponding figure for the District or Area Medical Committee. The overall picture of committee activity among GPs is that it is a minority activity but that the Local Medical Committee was the most important in

terms of current and past membership.

Among the sample of GP team members the findings are very different. Table 5.5 shows that all but one GP team member was a member of the District/Area Medical Committee at the time of the survey. Eighty-one per cent of respondents were currently members of the LMC and a further 7% had previously been members. While team membership demanded membership of the District or Area Medical Committee, there was no such formal relationship with the Local Medical Committee. Additionally 43% of team members were also members of the Family Practitioner Committee and a quarter of the respondents belonged to a Health Care Planning Team. It is clear that GP team members showed a radically different pattern of committee membership to that of the sample of practising GPs. Two processes seem to have been at work; team members were selected from among GPs who were active in advisory and professional committees, and for some, team membership resulted in membership of other committees and teams. For instance, one Local Medical Committee (LMC) Secretary openly expressed the view that all GP members of management teams should automatically belong to the LMC since that was the focus of GP views and opinions.

These findings were similar for GP members of District and Area Management Teams (DMT/AMT) with the exception that AMT GPs were more likely to belong to the Family Practitioner Committee (71%) than were DMT GPs (37%). This finding must be interpreted with caution since only 14 GP Area Management Team members were included (see Table 5.6).

The importance of the Local Medical Committee will be discussed below (see chapter 7) but three points can be made at this stage. The LMC was regarded by GPs as the natural representative body as is shown by their membership patterns. Secondly, membership of the LMC was thought to provide valuable knowledge and information necessary for the GP team member.

Thirdly the Chief Medical Officer's Working Party on the Advisory System at District level has accepted that the Local Medical Committee fulfils a similar function for GPs as the Medical Executive or Medical Staff Committee for hospital doctors (DHSS, 1980A).[5] The Local Medical Committee was seen as the appropriate source of advice on matters of interest to GPs despite the lack of geographical coterminosity.

Another structural factor which affects the representation system is the means of selection of the GP team member. While the medical advisory committee was given statutory recognition at the Area level, the District Medical Committee was not obligatory nor was the method for selecting the GP member of the management team (DHSS, 1972). The Grey Book suggested that the clinical team members should be chairman and vice-chairman of the District or Area Medical Committee and elected by the DMC/AMC members. Brown commented that this constituted a form of indirect representation and placed one layer of representative machinery between the clinical team member and the practising doctor (Brown, 1979). Therefore the first question to be answered concerns the selection of District or Area Medical Committee members from whom and by whom the clinical team members were to be selected. Since District or Area Medical Committee members were not surveyed, the GP team members were questioned about their membership of the DMC/AMC and the results are summarised in Table 5.7. From the GP team member survey it was found that 62% of respondents had joined the District or Area Medical Committee at its inception in 1974 and a further 20% had joined in 1976 or 1977.[6] Table 5.8 shows that only 28% of the GP team members had joined the management team in 1974. It would appear that the recommended process of selection of team members from the membership of the District or Area Medical Committee membership had been followed in many districts or areas in the years immediately following the 1974 reorganisation. There was evidence that at the time of the survey

the District and Area Medical Committees were falling into disuse in some localities and this question is discussed in detail below (Page, 1981).[7] The District or Area Medical Committee potentially formed an important means of socialisation for GPs since it dealt with issues germane to the district or area while the Local Medical Committee was likely to deal with issues at a different level of generality since the membership's interests were not restricted to a single health district.

It was argued above that the selection process might be an important means of authorising the GP team member to act as a representative of the GPs in his area or district.[8] The GP survey included a question designed to see whether practising GPs took any part in the selection of GP members of the District or Area Medical Committee - the first stage of the selection of the GP team member. Table 5.9 shows that only 27% of respondents claimed to have taken any part in the selection of District or Area Medical Committee members and 66% claimed they had taken no part. It must be concluded that practising GPs do not view the District or Area Medical Committee as an elected body. In a supplementary question to examine the form of this participation 13 GPs mentioned an election and the remaining 23 mentioned some form of nomination possibly through the Local Medical Committee or the Cogwheel system (see Table 5.10). Thus District or Area Medical Committee members are found from among the membership of professional and advisory committees and nominated or appointed to the committee by them.

It is clear that the links between GP members of the District or Area Medical Committee and ordinary GPs are tenuous. Two explanations suggest themselves; either most GPs are content to be 'represented' by interested colleagues who are prepared to put in the appropriate effort, or GPs see little benefit to be obtained from participation and are indifferent or even hostile to it. If the GP members of District or Area Medical

Committees can be said to be representative of their colleagues it is only true in the microcosmic or type-representative sense.

Since the GP members of the District or Area Medical Committee only represent their colleagues in a minimalist sense, then the nature of the GP team members 'representative role' must be called into question. Table 5.11 shows that 81% of District/Area Medical Committee Secretaries reported that the chairmen and vice-chairmen - the clinical members of the management team - were elected by the committee while two districts and two areas operated a rotation system. An equal number of GPs and consultants were chairman of the District or Area Medical Committee but there was the suggestion that consultants were more likely to be chairman of the Area Medical Committee in single district areas (see Tables 5.12, 5.13).

An important feature of the election was argued to be the constraints which it placed upon the elected representative. It was argued before reorganisation that the limited tenure of the representative contributed to the acceptability of his role to his colleagues.[9] It was evident from Table 5.8 that three or four years seemed to be a widely recognised term of office for GP team members and that two new waves of members were selected in 1977 and 1978 which together accounted for almost half of the sample. From the District/Area Medical Committee Secretary survey it was found that 59% of DMC/AMC chairmen were selected for a period of two or more years and a further 10% for an unspecified period (see Table 5.14). Eleven (18%) District Medical Committee Secretaries reported that their chairman and vice-chairman were elected for less than one year and the corresponding figure for the Area Medical Committees was 7 (39%). Limited tenure may indicate that the membership of the committee wish to restrict the authority of their representatives on the management team or that the team members are unwilling to commit themselves for more than one year in advance. It

was also found from the GP team members' survey that 10% of the respondents were ordinary members of the District/Area Medical Committee and that four DMC/AMCs had been suspended (Table 5.15).[10] In the majority of cases (84%) the GP team members were either chairmen or vice-chairman of the District/Area Medical Committee. In a small number of cases team membership had been divorced from chairmanship of the medical advisory committee. This may reduce the workload for the team member but it also appears to break a formal link between the advisory and the management systems. The significance of a break in this link is discussed below.

The surveys of District/Area Medical Committee Secretaries and practising GPs suggested that the GP members of the DMC/AMC are seldom elected by their colleagues although DMC/AMC membership precedes team membership, which usually accompanied chairmanship or vice-chairmanship of the DMC/AMC. Table 5.16 showed that 69% of medical advisory committees elected their own chairman while a substantial minority used either a rotation scheme (16%) or some other means which usually involved consultation with the Local Medical Committee (11.1%). There appeared from the answers to the questionnaire to be some confusion between who actually selected the team member and who had formal responsibility for that selection. There was some indication that those DMC secretaries who were administrators rather than doctors were more willing to accept that the formal blueprints of the Grey Book provided an accurate description of the procedure adopted within the particular district.

The Local Medical Committee survey examined this question further by asking whether the LMC selected the GP member of the management team. This question provoked some comment and quoting of the appropriate passages from the Grey Book but the response showed that 63% of LMC secretaries thought their committee selected the GP team member (Table 5.17). It was expected that this pattern would characterise Area Management Teams rather

than District Management Teams since the relationship between DMTs and LMCs was expected to be more distant than that between AMTs and LMCs due to the situation of LMCs at the area level. The response to the LMC survey supported this contention since 76% of LMCs claimed to select the GP member of the Area Management Team while only 53% claimed to select the members of District Management Teams.

A supplementary question asked those LMC secretaries who claimed the LMC selected the GP team member to describe the means the LMC used in this selection. The means of selection identified were informal in that 46% claimed to nominate the team member and a further 6% ratified the selection of the LMC district sub-committee (Table 5.18). This was in marked contrast to the formal procedures used to elect Local Medical Committee members in which there were fixed constituencies with elections for membership of the main committee. Comparing LMCs in single-district areas with those in multi-district areas it was found that the LMC nominated the GP team member in 67% of the former and only 30% in the latter.

The pattern of selection of GP representatives must be understood in terms of two factors. Firstly, the demands of the position outweigh those of any other representative position filled by the GP (with the possible exception of Local Medical Committee secretary).[11] Therefore it is not a position to be undertaken lightly. Secondly the Local Medical Committees are increasingly recognising the importance of the GP team member as an equal member of the management team in districts or areas and as a potentially strong advocate for the GPs' interests.

5.3 The Local Medical Committee and the Representative Process

The Local Medical Committees were established in 1911 to pursue the interests of GPs by advising and attempting to influence the local insurance

committees (Forsyth, 1966). After 1948 the local insurance committees were abolished and the LMC came to play the same role in relation to the Local Executive Councils which held the contracts of independent practitioners. It can be concluded that the LMC was well established in the eyes of GPs at the time of the 1974 reorganisation but it did not fit in with the advisory system which was recommended. In contrast the District/Area Medical Committees had no obvious predecessor since they were supposed to represent the full range of medical views from doctors working in each section of the 'unified NHS'. Similarly the concept of an agreed medical view which the District or Area Medical Committee was supposed to produce was foreign and it was not clear on what issues medical consensus was needed or possible.[12]

The LMC provided a representative body for GPs at the County or Area level but there was no widespread pattern of GP committees at the district level. In multi-district areas 43% of LMCs had a district sub-committee system (Table 5.19). These sub-committees were composed of the members of the full LMC for the LMC electoral constituencies within the district and sometimes GPs were co-opted to them. Table 5.19 shows that 17 of the 21 LMCs with district sub-committees followed the boundaries of the health districts while 4 had significantly different boundaries. The importance of identical boundaries lies in the extent of shared interests and the degree to which those interests concern issues particular to the health district rather than issues which affect GPs over a number of districts, areas or regions and therefore relate to levels of authority above the district.

A supplementary question concerned the extent of the activity of Local Medical Committee district sub-committees of which the frequency of meetings is one indication. Clearly the frequency of meetings and the volume of business conducted do not necessarily correlate. Three broad categories of

activity can be identified in the Local Medical Committees in multi-district areas: those LMCs with no district sub-committees; those with district sub-committees which meet regularly whether that is monthly, two monthly or quarterly; and those with sub-committees which meet on an ad hoc or annual basis. In the first category the LMC must consider items relating to particular districts using the same mechanisms as for other business namely: the formal meeting, an executive committee, or through action by the secretary and his staff. In the second category the sub-committee can potentially monitor the progress of particular issues or provide regular advice for the LMC or the district. In the third category the mechanisms are available for considering particular issues but these are likely to be irregular or unpredictable and this response would suggest only an infrequent monitoring activity.

Table 5.20 shows that 16 of the 21 LMCs with district sub-committees reported that the sub-committees met at least quarterly and the remaining five met on an annual or ad hoc basis. There was no clear correlation between the number of districts within an area and the existence or activity of local sub-committees of the LMC.

Table 5.21 shows that only 18 of the 21 LMCs with district sub-committees operated a system of regular reports from the sub-committee to the main Local Medical Committee. It appears that only one-third of LMCs in multi-district areas operate a district sub-committee system in an attempt to ensure that the main LMC keeps abreast of issues relating to particular districts or that medical advice is provided for the health district on GP interests. Table 5.22 shows that three LMCs had sub-committees which reported only on an 'ad hoc' or annual basis which suggests a residual or 'watchdog' function rather than an integral part of LMC activity.

A minority of LMCs in multi-district areas used a district sub-committee system to cope with the boundary problems between the committee and the health districts. The role of the LMC is discussed in more detail in Chapter 7.

5.4 The District/Area Medical Committee

Questions of membership go some way towards suggesting the range and nature of interests in a medical advisory committee but the variables relating to activity are more important. Indicators of the formal activity of a committee need to be examined alongside questions of the content of meetings and decisions and other indicators of process. First, however, the formal activity must be examined. In recent years the questions of formal structure have been of less interest to theoreticians and commentators than questions of process, and informal organisation.[13] Formal aspects of organisation may act as important negative constraints to organisational activity or as positive influences on the kind of activity performed. For instance the formal relationships through which the NHS receives resources and the nature of those resources and restrictions on their use greatly influence the direction of the organisation. Additionally, the separate funding of general practice has a significant impact on district services, and the nature of joint finance significantly affects new developments in services within districts.

Turning to the District/Area Medical Committees, Table 5.23 shows that there were no significant differences in the frequency of meeting between the two committees. Almost 90% met on at least a quarterly basis indicating a certain content of regular business. However 42% met monthly and there was no significant difference between DMCs and AMCs on this point. Since the District or Medical Advisory Committee was intended to provide advice for the management team through the clinical team members, the frequency

with which it met was an important indicator of the team members' perceptions of the need for broad based advice and the committee's ability to produce it. Table 5.24 shows the frequency of management team meetings demonstrating that 87% met at least fortnightly and 37% met every week. It follows from this that the medical committee could not possibly follow the detail of team business but would necessarily have to deal with the items of special interest to clinicians where there was some degree of controversy. Table 5.24 suggests that the Area Management Teams met more frequently than their district counterparts although this might be due to their direct relationship with a lay authority. It was also surprising that 9% of DMTs met only monthly although this may indicate a distinction between 'officers meetings' and full team meetings at which the clinical members were also present. It has been noted that in the West Midlands Region four Area Management Teams had separate officers' meetings and two did not send agendas and minutes to the clinical members. Also in Birmingham Area Health Authority (Teaching) all the DMTs were reported to have separate officers' meetings and papers were not seen by clinicians (Page, 1981, p.7-8).

As there was no clear relationship between the frequency of management team meetings and the frequency of medical advisory committee meetings, an explanation is needed for the frequency of medical committee meetings. One possible answer concerned the question of the setting of the District or Area Medical Committee Agenda. A District Administrator who was secretary of the DMC spelt it out in the following way,

> As Secretary, I made considerable efforts in the early months to put an interesting agenda supported by papers to the committee on such topics as Senior Medical Staff, Priorities in the Capital Programme and current problems. Not one member himself asked for an item to be put on the agenda and the committee was little more than a 'talking shop'.
>
> (District Administrator 47).

This response suggests that there was no obvious agenda for the committee and therefore the secretary felt it necessary to ensure that interesting items appeared giving the committee scope to work as intended. The suggestion is supported by the view that DMC members did not contribute items for the agenda.[14] The activity of the District/Area Medical Committee was always likely to depend to a large extent on the activity of its officers, - the Chairman, Vice-Chairman and Secretary and since the chairman and vice-chairman were usually the clinical team members the survey was addressed to the secretary.

The status of the secretary varied between different District and Area medical committees as tables 5.25 and 5.26 show. A distinction could be made between lay (70%) and medically qualified secretaries (26%) and also between those DMC/AMCs where the secretary was the District or Area Administrator (19%) from where an administrative assistant or committee clerk (51%) held the position (Tables 5.25, 5.26). It might be expected that medically qualified secretaries selected from amongst the membership of the committee would have a more directive role than committee clerks who simply service the committee. About a quarter of District Medical Committees had the District Administrator as their secretary and this might be expected to have influenced the nature of the committee since it may have four team members among its membership (the two clinical members, the community physician, and the administrator). The District Administrator as the co-ordinating member of the management team was well positioned to ensure that the appropriate advice was requested in advance of team meetings, especially when the District Medical Committee only met infrequently.

The most important group of the medically qualified secretaries were the District Community Physicians or Area Medical Officers who comprised

11% of the DMC/AMC secretaries in the sample. In only 5 cases was the secretary of the DMC/AMC also a clinical team member and this extension of his role usually involved a division of the secretarial function with a committee clerk or junior administrator to deal with the administrative aspects of the role.

Creation of the Agenda was an important factor contributing to the success of the DMC or AMC and Table 5.27 lists those with responsibility for its production. In a quarter of cases the chairman and secretary shared responsibility for the agenda and in 30% the chairman took sole responsibility. In 16% of cases the team officers took some part in the creation of agendas indicating that DMC/AMC advice was seen to have a bearing on team activity. A related issue concerns the origin of agenda items which throws light on the operation of DMCs in health districts and AMCs in the single-district area. The membership category in Table 5.28 excludes the clinical team members and showed firstly that in 41% of DMC/AMCs the secretary reported that the membership seldom contributed items to the agenda. In comparison 50% of chairmen frequently contributed items and 33% were placed in the sometimes category. While these findings concern the secretary's perception of reality, they suggest that an active chairman raises issues for discussion but that the membership are passive, at least insofar as raising issues for discussion.[15] There is no doubt that a significant proportion of its agenda is likely to concern what Hunter has referred to as Standard Operating Procedures (SOPs) where particular patterns of action routinely take place in dealing with particular problems (Hunter, 1980). For instance, the draft planning documents may routinely be circulated to the DMC/AMC for comment and other documents which may concern the services provided locally may be discussed regularly.

Table 5.30 shows that only 14% of practising GPs reported ever having raised an item for the DMC to discuss.[16] Thus the majority of GPs have no direct input to the District or Area Medical Advisory Committee. They may however raise issues with the GP team member or with the Local Medical Committee secretary personally.

5.5 The District/Area Medical Committee as a Constituency Body

The structure of the District/Area Medical Committee was discussed above in relation to the selection of DMC/AMC members and clinical members of the DMT/AMT. Evidence from the Local Medical Committee secretaries suggested that the clinical team members were selected after wide consultation, especially in the case of the GP. The survey of practising GPs demonstrated that most GPs felt that they took no direct role in the selection of the GP team member, although a few felt that the LMC took part on their behalf. The overwhelming impression to arise was that a minority of GPs took part in the local professional and advisory committees and that the GP team member was selected from among that minority group.

The role of the District/Area Medical Committee was examined through the surveys to see whether it could reasonably be regarded as a proxy constituency for the range of doctors practising in the district. A model constitution was described in the DHSS Circular HRC(74)9 which suggested three equal groups of doctors representing general practice, hospital medicine, and community health doctors. Table 5.31 shows that the recommendation that there should be similar numbers of GPs and hospital doctors was carried out in all but one of the DMC/AMCs in which consultants had withdrawn their co-operation. The concept of numerical balance does not necessarily indicate a microcosmic view of the DMC/AMC as a small scale version of the district or area but implies that where hospital doctors and GPs have different interests these should not be resolved by numerical superiority.

Looking at two main groups of the other section of doctors belonging to the DMC/AMC it is notable that 62% of DMC/AMCs had only a single community physician and 39% had no representation of junior doctors (Table 5.32). This suggests that the hierarchical nature of community medicine meant that the District Community Physician or Area Medical Officer as head of the specialty was widely seen as the most appropriate representative or spokesman for that specialty and that the consultant members of the DMC/AMC were regarded as competent to speak for their 'juniors'.

Table 5.1 GP partnership sizes in the GP Sample, the GP team member sample and the population of GPs in England and Wales 1979
(percentages in brackets)

Partnership Size	GP sample		GP team members		GP Population[1]	
1 Doctor	12	(9.02)	2	(2.3)	3,332	(14.7)
2 Doctors	17	(12.78)	13	(14.6)	4,322	(19.0)
3 Doctors	35	(26.3)	24	(27.0)	5,480	(24.1)
4 or more Doctors	69	(51.9)	49	(55.1)	9,566	(42.2)
Total	133	(100)	89	(100)	22,700	(100)

(percentages are calculated downwards)

[1]The GP population for England and Wales was calculated from the DHSS Health and Personal Social Service Statistics for England 1982 and the Welsh Office Health and Personal Social Service Statistics for Wales 1980.

GP team member question 1
GP sample question 1

Table 5.2 GP partnership sizes for England and Wales in the years 1971 and 1979 (unrestricted principals)
(percentages in brackets)

Partnership Size	1971		1979	
1 Doctor	4,152	(20.1)	3,332	(14.7)
2 Doctors	4,880	(23.7)	4,322	(19.0)
3 Doctors	5,262	(25.5)	5,480	(24.1)
4 or more Doctors	6,339	(30.7)	9,566	(42.2)
Total	20,633	(100)	22,700	(100)

(percentages calculated downwards)

From DHSS Health and Personal Social Service Statistics for England 1978 and 1982 and the Welsh Office Health and Personal Social Services for Wales 1974 and 1980.

Table 5.3 Present and past membership of committees amongst GP sample

(percentages in brackets)

Number of Committees	Present Membership		Past Membership	
No Committees	115	(86.5)	95	(71.4)
1 Committee	9	(6.7)	32	(24.1)
2 Committees	5	(3.8)	6	(4.5)
3+ Committees	4	(3.0)	-	-
Total	133	(100)	133	(100)

(percentages are calculated downwards)

GP sample question 4

Table 5.4 Present and past membership of committees amongst GP sample

(percentages in brackets)

Committee	Present Membership		Past Membership		Total No.	
Family Practitioner Committee	3	(2.25)	5	(3.76)	8	(6.01)
Local Medical Committee	10	(7.52)	21	(15.79)	31	(23.3)
Health Care Planning Team	9	(6.77)	3	(2.25)	12	(9.02)
Cogwheel Division	2	(1.5)	4	(3.01)	6	(4.51)
District/Area Medical Committee	7	(5.26)	10	(7.52)	17	(12.78)
District/Area Management Team	-	-	1	(0.75)	1	(0.75)

(percentages calculated across)

GP sample question 4.

Table 5.5 Present and past membership of committees amongst GP team member sample

(percentages in brackets)

Committee	Present Membership total = 89		Past Membership total = 89		Total total = 89	
Family Practitioner Committee	38	(42.69)	9	(10.11)	47	(52.8)
Local Medical Committee	72	(80.89)	6	(6.74)	78	(87.64)
Health Care Planning Team	22	(24.72)	15	(16.85)	37	(41.57)
Cogwheel Division	10	(11.23)	3	(3.37)	13	(14.61)
District/Area Medical Committee	88	(98.88)	-		88	(98.88)
District/Area Management Team	89	(100)	-		89	(100)

(percentages calculated across)

GP team member questions 2,3.

Table 5.6 Present membership of committees by GP team members from single district areas and health districts

(percentages in brackets)

Committee	Current Membership GP members of DMTs total = 75		Current Membership GP members of AMTs total = 14		Total Membership Total = 89	
Family Practitioner Committee	28	(37.33)	10	(71.42)	38	(42.69)
Local Medical Committee	58	(77.33)	14	(100.0)	72	(80.89)
Health Care Planning Team	18	(24.0)	4	(28.57)	22	(24.72)
Cogwheel Division	10	(13.3)	-		10	(11.23)
District/Area Medical Committee	74	(98.67)	14	(100)	88	(98.88)
District/Area Management Team	75	(100)	14	(100)	89	(100)

(percentages calculated across)

GP team member question 2,3.

Table 5.7 Year of selection to district/area medical committee of GP members of district/area management teams

(percentages in brackets)

Date joined District/ Area Medical Committee	District Management Team		Area Management Team		Total	
Not Applicable	1	(1.33)	-		1	(1.12)
1974	48	(64.0)	7	(50.0)	55	(61.79)
1975	2	(2.67)	-		2	(2.25)
1976	8	(10.66)	1	(7.14)	9	(10.11)
1977	8	(10.66)	1	(7.14)	9	(10.11)
1978	5	(6.66)	3	(21.42)	8	(8.98)
1979	3	(3.99)	2	(2.67)	5	(5.62)
Total	75	(100)	14	(100)	89	(100)

(percentages calculated downwards)

GP team member question 12.

Table 5.8 Year in which respondent became GP team member of the district or area management team

(percentages in brackets)

Year	District Management Team		Area Management Team		Total	
1974	21	(28.0)	4	(28.57)	25	(28.09)
1975	2	(2.66)	-		2	(2.25)
1976	8	(10.66)	1	(7.14)	9	(10.11)
1977	17	(22.66)	2	(14.28)	19	(21.35)
1978	19	(25.33)	4	(28.57)	23	(25.84)
1979	8	(10.66)	3	(21.42)	11	(12.36)
Total	75	(100)	14	(100)	89	(100)

GP team member question 12

Table 5.9 Whether GPs took part in the selection of district/area medical committee members

(percentages in brackets)

Response	GP Sample	
No Answer	1	(0.75)
Yes	36	(27.06)
No	88	(66.16)
Don't Know	8	(6.01)
Total	133	(100)

(percentages calculated downwards)

GP sample question 5.

Table 5.10 Means by which GPs participate in selection of district/area medical committee members

(percentages in brackets)

Means of Participation	GP Sample	
No Answer	3	(2.25)
Not Applicable	96	(72.18)
Election	13	(9.77)
Nomination	6	(4.51)
Cogwheel	8	(6.01)
LMC Appointment	7	(5.26)
Total	133	(100)

(percentages calculated downwards)

GP sample question 6.

Table 5.11 Means of selection of chairman and vice-chairman of the district/area medical committee

(Percentages in brackets)

Means of Selection of Chairman and Vice-Chairman	District Medical Committee		Area Medical Committee		Total	
Election	50	(80.64)	15	(83.3)	65	(81.25)
Rotation	4	(6.45)	2	(11.11)	6	(7.5)
Other	8	(12.90)	1	(5.5)	9	(11.25)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 9.

Table 5.12 Number of consultants and GPs who were chairmen of the district/area medical committee in districts and single-district areas

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
Consultant	28	(45.16)	13	(72.2)	41	(51.25)
GP	34	(54.84)	5	(27.7)	39	(48.75)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 7.

Table 5.13 Number of consultants and GPs who were vice-chairman of the district/area medical committee in districts and single-district areas

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
Consultant	33	(53.22)	6	(33.3)	39	(48.75)
GP	27	(43.55)	12	(66.6)	39	(48.75)
Other	2	(3.22)	-		2	(2.5)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 8.

Table 5.14 Tenure of chairman and vice-chairman of district/area medical committees

(percentages in brackets)

Tenure	District Medical Committee		Area Medical Committee		Total	
Less than 1 year	11	(17.74)	7	(38.88)	18	(23.75)
Between 1 and 2 years	6	(9.67)	1	(5.55)	7	(8.75)
For 2 or more years	39	(62.9)	8	(44.44)	47	(58.75)
Tenure not specified	8	(9.67)	2	(11.11)	8	(10.00)
Total	62	(100)	18	(100)	80	(199)

(percentages calculated downwards)

District Medical Committee Secretary question 10.

Table 5.15 Position held by GP team member on the district/area medical committee in districts and single-district areas

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	-		1	(7.14)	1	(1.12)
Chairman	40	(53.3)	6	(42.86)	46	(51.68)
Vice-Chairman	25	(33.3)	4	(28.57)	29	(32.58)
Ordinary Member	6	(8.0)	3	(21.43)	9	(10.11)
DMC/AMC Suspended	4	(5.3)	-		4	(4.49)
Total	75	(100)	14	(100)	89	(100)

(percentages calculated downwards)

GP team member question 4.

Table 5.16 Means by which chairman and vice-chairman of the district/area medical committee are selected

(percentages in brackets)

Method of Selection	District Medical Committee		Area Medical Committee		Total	
No Answer	-		1	(7.14)	1	(1.12)
Election	52	(69.3)	9	(64.28)	61	(68.54)
Rotation	12	(15.99)	2	(14.28)	14	(15.73)
Other	8	(10.66)	2	(14.28)	10	(11.23)
Not Applicable	3	(3.99)	-		3	(3.37)
Total	75	(100)	14	(100)	89	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 9.
GP team member question 5

Table 5.17 Whether the local medical committee select the GP member of the district/area management team

(percentages in brackets)

LMC Secretary Response	GP Members of DMT		GP Members of AMT		Total	
Yes	26	(53)	26	(76)	52	(63)
No	23	(47)	8	(24)	31	(37)
Total	49	(100)	34	(100)	83	(100)

(percentages calculated downwards)

Local Medical Committee Secretary Multi-District Area question 24, and Single-District Area question 17.

Table 5.18 Means by which LMC selects GP member of district/area management team

(percentages in brackets)

Method of Selection	GP Members of DMT		GP Members of AMT		Total	
Elect	6	(12.24)	2	(5.88)	8	(9.6)
Nominate	15	(30.6)	23	(67.65)	38	(45.8)
Ratify	3	(6.1)	-		3	(3.6)
District Sub-Committee	2	(4.08)	-		2	(2.4)
Chairman	-		1	(2.94)	1	(1.2)
Not Applicable	23	(46.94)	8	(23.53)	31	(37.3)
Total	49	(100)	34	(100)	83	(100)

(percentages calculated downwards)

Local Medical Committee Secretary Multi-District Area question 25, and Single-District Area question 18.

Table 5.19 Whether district sub-committees of the LMC are conterminous with the health districts within LMC boundaries?
(percentages in brackets)

Boundaries of LMC Sub-Committee and Health Districts	Multi-District Areas[1]	
Boundaries identical	17	(34.7)
Different Boundaries	3	(6.12)
Some Boundaries identical	1	(2.04)
Not Applicable	28	(57.14)
Total	49	(100)

(percentages calculated downwards)

[1]The table is only concerned with boundaries of LMC sub-committees in multi-district areas.

Local Medical Committee Secretary Multi-District Areas questions 16 and 17.

Table 5.20 Frequency of local medical committee local sub-committee meetings in multi-district areas
(percentages in brackets)

Frequency	LMC "Areas"[1]	
Monthly	6	(12)
Two monthly	6	(12)
Three monthly	4	(8)
As required	3	(6)
Annual	2	(5)
Not Applicable (No sub-committees)	28	(57)
Total	49	(100)

(percentages calculated downwards)

[1]Category includes all LMCs responding which were coterminous with multi-district areas.

Local Medical Committee Secretary Multi-District Areas question 18.

Table 5.21 Number of LMCs with district sub-committees which report regularly to the LMC

(percentages in brackets)

Response	LMC Areas	
Yes	18	(37)
No	3	(6)
Not Applicable (no sub-committees)	28	(57)
Total	49	(100)

(percentages calculated downwards)

Local Medical Committee Secretary Multi-District Area questions 16 and 19.

Table 5.22 Frequency with which local medical committees received reports from their district sub-committees

(percentages in brackets)

Frequency of Reports	LMC response	
Monthly	6	(13)
Two monthly	4	(8)
Three monthly	5	(10)
Ad hoc	1	(2)
Annual	2	(4)
Sub-Committee not report	3	(6)
No Sub-Committee	28	(57)
Total	49	(100)

(percentages in brackets)

Local Medical Committee Secretary Multi-District Areas question 21.

Table 5.23 Frequency of meetings of district/area medical committees

(percentages in brackets)

Frequency of Meetings	District Medical Committees		Area Medical Committees		Total	
Monthly	27	(44)	7	(39)	34	(42)
Two Monthly	18	(29)	3	(17)	21	(26)
Three Monthly	12	(19)	5	(28)	17	(21)
Other (on regular basis)	2	(3)	1	(5)	3	(4)
As Required	3	(5)	2	(11)	5	(7)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 6.

Table 5.24 Frequency of district/area management team meetings

(percentages in brackets)

	District Management Teams		Area Management Teams		Total	
Weekly	26	(34.2)	10	(50)	36	(37.5)
Fortnightly	41	(53.95)	8	(40)	49	(51)
Three Weekly	2	(2.63)	1	(5)	3	(3.12)
Monthly	7	(9.21)	1	(5)	8	(8.33)
Total	76	(100)	20	(100)	96	(100)

(percentages calculated downwards)

District Administrator question 7.

Table 5.25 Occupation or specialty of district/area medical committee secretary

(percentages in brackets)

Occupational Group	DMC Secretary		AMC Secretary		Total	
Administrator (GAA etc.)	30	(48.38)	11	(61)	41	(51.25)
District/Area Administrator	15	(24.19)	-		15	(18.75)
Community Physician	5	(8.06)	4	(22.2)	9	(11.25)
GP member of DMT/AMT	4	(6.45)	1	(5.5)	5	(6.25)
Consultant	3	(4.84)	1	(5.5)	4	(5.0)
GP	3	(4.84)	-		3	(3.75)
Abolished	2	(3.22)	1	(5.5)	3	(3.75)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee question 1.

Table 5.26 District/area medical committees having medical or lay secretaries

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
Lay Secretary	45	(72.58)	11	(61.1)	56	(70)
Medical Secretary	15	(24.19)	6	(33.3)	21	(26.25)
Abolished	2	(3.22)	1	(5.5)	3	(3.75)
Total	62	(100)	18	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee question 1.

Table 5.27 Person responsible for creating the agenda of district/area medical committee

(percentages in brackets)

	District Medical Committee		Area Medical Committee	
Chairman and Vice-chairman	29	(32.26)	5	(28)
Chairman and Secretary	17	(27.42)	3	(17)
Secretary	15	(24.19)	7	(39)
Shared Responsibility or DMT/AMT	10	(16.13)	3	(17)
Total	62	(100)	18	(100)

(percentages calculated downwards)

District Medical Committee Secretary question 11.

Table 5.28 Frequency with which chairman, vice-chairman and members of the district/area medical committee submit items for agenda

(percentages in brackets)

Frequency	Chairman		Vice-Chairman		Members	
Frequently	40	(50)	8	(10)	9	(11.25)
Sometimes	27	(33.75)	37	(46.25)	28	(35.0)
Seldom	11	(13.75)	21	(26.25)	33	(41.25)
Never	2	(2.5)	11	(13.75)	9	(11.25)
Not Applicable	-		3	(3.75)	1	(1.25)
Total	80	(100)	80	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee question 12.

Table 5.29 Frequency that GP team members raise issues for discussion at DMC/AMC meetings

(percentages in brackets)

	GP Team Members DMC		GP Team Members AMC		Total	
No Answer	-		1	(7.1)	1	(1.12)
Frequently	27	(35.9)	2	(14.28)	29	(32.58)
Sometimes	33	(43.9)	4	(28.57)	37	(41.57)
Seldom	10	(13.3)	4	(28.57)	14	(15.73)
Never	1	(1.3)	3	(21.4)	4	(4.49)
Not Applicable	4	(5.3)	-		4	(4.49)
Total	75	(100)	14	(100)	89	(100)

(percentages calculated downwards)

GP team member question 11.

Table 5.30 Number of GPs who had ever raised an issue for the district/area medical committee agenda

(percentages in brackets)

Response		
Not Applicable	1	(0.75)
Yes	19	(14.28)
No	112	(84.2)
Don't Know	1	(0.75)
Total	133	(100)

(percentages calculated downwards)

GP sample question 7.

Table 5.31 Number of GP and consultant members of district/area medical committees

(percentages in brackets)

Number of GP and Consultant Members	District/Area Medical Committees	
No Consultants	1	(1.25)
DMC Abolished	1	(1.25)
2 Consultants, 2 GPs	1	(1.25)
4 Consultants, 4 GPs	3	(3.75)
5 Consultants, 5 GPs	25	(31.25)
6 Consultants, 6 GPs	23	(28.75)
7 Consultants, 7 GPs	7	(8.75)
8 Consultants, 8 GPs	8	(10.0)
9 Consultants, 9 GPs +	11	(13.75)
Total DMC/AMC	80	(100)

(percentages calculated downwards)

District Medical Committee question 4

Table 5.32 Number of community physicians, junior hospital doctors and university representatives on district/area medical committees

(percentages in brackets)

Number of Doctors on DMC/AMC	Community Physicians		Junior Hospital Doctors		University Representatives	
0	3	(3.75)	31	(38.75)	69	(86.25)
1	50	(62.5)	49	(50.00)	11	(13.75)
2	23	(28.75)	8	(10.0)	-	
3	1	(1.25)	1	(1.25)	-	
4	1	(1.25)	-		-	
5	1	(1.25)	-		-	
6	1	(1.25)	-		-	
Total	80	(100)	80	(100)	80	(100)

(percentages calculated downwards)

District Medical Committee question 4.

CHAPTER 6

THE DISTRICT/AREA MEDICAL COMMITTEE AND THE CREATION OF EXPECTATIONS

6.1 Introduction

The last chapter dealt with the process of representation and described the activity of practising GPs, the medical advisory and professional committees, the GP team member, and the management team within that process. This chapter concentrates upon the behaviour of the District/Area Medical Committee (DMC/AMC) as a body composed of constituents, (although unrepresentative of those constituents in important respects), in the creation of expectations, the means of decision-making which are employed, the content of expectations, the transmission of expectations, and the question of representative accountability.

6.2 The Creation of Policy by the District/Area Medical Committee

The District/Area Medical Committee (DMC/AMC) was conceived as a means to obtain broadly-based medical advice for the management team and health authority and thereby reconcile the differences of interest between doctors working in the three sections of the service. It was suggested above that the DMC/AMC may act as a substitute for the active personal involvement of the majority of doctors (particularly GPs) working in the district who take no part in professional or advisory machinery. This section examines the means by which the DMC/AMC produces policies or comes to agreement on particular issues.

A significant aspect of DMC/AMC agendas was that they contained minutes and reports from other professional and advisory committees, and sometimes the management team. The inclusion of such minutes and reports in the agenda potentially fulfilled a number of different purposes. The most obvious was that they provided a source of information which ensured a degree of communication between the DMC and other committees and teams. Frequently

these minutes were simply "noted" or "received" and no further action was taken, suggesting that the minutes were simply a means of informing the DMC/AMC of issues relevant to their task. The second function was to enable a committee representative of one group of doctors to inform the DMC/AMC of the views or expectations of that particular group. For instance, the Medical Executive Committee (MEC) or the Medical Staff Committee (MSC) as the representative bodies of hospital doctors, frequently sent minutes to inform the DMC/AMC of their views, expectations or intentions. This did not, of course, preclude these committees from pursuing their interests in other ways. The third function of minutes and reports was that they allowed a certain amount of monitoring to take place by the DMC/AMC of the activity of other committees.[1] The function of monitoring suggests that the DMC/AMC was able to undertake activity to influence the activity, views or intentions of these committees. Fourthly the DMC/AMC could employ minutes and reports in their role of co-ordinating the views from various medical groups and arriving at broadly based medical priorities.

The minutes of other committees may be included in the DMC/AMC agenda for any or all of these purposes and Table 6.1 shows the range of committees whose minutes appeared in these agendas. The first category is the minutes of statutory bodies; the Family Practitioner Committee (FPC) and the District or Area Management Team (DMT/AMT). The DMC/AMC might be expected to monitor the minutes of these two bodies because the FPC was responsible for the services provided by independent contractors and the DMT/AMT for the operational management of district services. The second category includes the Cogwheel Divisions and the Medical Executive Committee which were responsible for ensuring that the views of hospital doctors are taken into account in the organisation of medical work in hospitals, and the implementation of agreed policies. The third category was the Local

Medical Committee which was the recognised GP committee. The fourth category concerned the Health Care Planning Team which was responsible for producing plans covering particular services in the District or Area. It was likely that the DMC/AMC would wish to monitor the planning system and ensure that their views were fully taken into account in the creation of plans. Finally the minutes of the Community Health Council (CHC) may be of interest to the DMC/AMC in particular instances such as the closure of a peripheral hospital where the CHC has its statutory rights.

The first point to note from Table 6.1 is the relatively low proportion of DMC/AMCs which received minutes from the DMT/AMT in their agenda. Only 48% of DMCs and 33% of AMCs included minutes or reports from the appropriate team in their agenda. The most likely explanation for this finding was that the DMC/AMC met relatively less frequently than the management team and also that the volume of work undertaken by the management team was such that the volume of papers would be overwhelming.[2] The implication of this finding is that the members of the DMC/AMC are dependent upon team members for their information about team activity and issues. In many cases the Chairman and Vice-Chairman are the source of information for the DMC/AMC although the administrator and community physician may also be members of the committee. Thus the DMC/AMC members are dependent upon the chairman and vice-chairman for the information concerning the "team agenda". This term is used in the sense of those issues which are being discussed at any particular time with a view to a decision or policy being made; not in the sense of an agenda paper. The finding that only 5% of DMC/AMCs received Family Practitioner Committee (FPC) minutes indicates the nature of FPC activity and its relationship with the services provided by the Health District or Area Health Authority.

Less than one DMC/AMC in five received minutes or reports from the Cogwheel system or the Medical Executive Committee although 30% received minutes from the Local Medical Committee. A quarter of DMCs received minutes from the Health Care Planning Teams and only 2 received minutes from the Community Health Council. These findings are restricted to the formal links between the DMC/AMC and the other main professional, advisory and management committees but they suggest that in formal terms the DMC/AMC is relatively isolated from the other professional and advisory committees in the district or area. The consequences are that members receive accounts of the views of these bodies through informal rather than formal mechanisms, the most important of which is likely to be "cross-representation". This is usually used to refer to individuals who are simultaneously members of more than one professional, advisory or management committee, and so able to form a "link" between those committees, acting as a source of information for each of the committees he belongs to.

There was a certain amount of evidence about cross-representation in the discussion of the selection of members of the DMC/AMC and the GP team member[3]. The cross-representation between the DMC/AMC and DMT/AMT is formally established in the role of the clinical team-member who also simultaneously belonged to other committees in most cases .

The question still remains to be answered as to how other items on the DMC/AMC agenda come to be raised. It was noted above that the membership seldom raised issues although the chairman and vice-chairman frequently placed items on the agenda (see page 132). In many of the examples given by respondents, members of the DMC/AMC made complaints about the administration of services and access to hospital services for GPs although in some cases such questions were resolved by direct action through the GP team member or the appropriate officer. A number of responding GP team members painted the picture of a passive, reactive rather than "proactive" DMC,

> ... our DMC is largely a committee which receives a report of DMT activities, of Cogwheel, Hospital Medical Advisory, Area Medical Committee and so forth. Traditionally, since 1974, little debate in fact little real activity has taken place in that forum and members have been known to ask whether we could dispense with it.
>
> (GP team member 118).

Another GP team member expressed very similar ideas,

> In the main this DMC is not one that takes initiatives. Issues of hospital/GP interface are discussed and in addition the DMC is supporting of views expressed by the clinician members of the DMT where they need a wider forum.
>
> (GP team member 050)

Both respondents suggested a role in which the DMC/AMC reacted to the views and expectations of other committees rather than initiating new developments itself.

To examine this assumption further the GP team members' sample was asked whether the DMC/AMC had agreed any policies which it wished the team to implement, and a supplementary question concerning the content of those policies. It can reasonably be objected that the DMC/AMC is not a policy-making body but an advisory committee, albeit with the suggestion of executive responsibilities in the implementation of policies. Nevertheless the DMC/AMC was designed to reconcile different interests and agree broad sets of priorities and it is in this sense that the word policy is used. Table 6.2 shows that the GP team members replied that a fifth of DMCs and a half of AMCs had not agreed on any policies on which the management team could act. However, GP team member 002 suggested that the DMC could be important in cases of a large capital project,

> ... the DMC takes up matters brought to its notice by consultant or GP members and makes recommendations. As we have just completed commissioning a new hospital there were many recommendations by the DMC.

A major development within a district implies a wide range of decisions to be made and a wide range of interests and this environment is very different to that of a district or area which has no extra capital or revenue resources, where there is little scope for new developments, and change is perceived as only possible in marginal or incremental terms.

It appears that the majority of DMC/AMCs did not either initiate issues for discussion by the management team or monitor the activities of the team or of other professional and advisory committees. The clinical members of the team may have carried out these roles on the committee's behalf, raising issues for discussion where a broad medical view was required, or where competing interests needed to be reconciled.[4] Nonetheless there was a considerable amount of variation between different DMC/AMCs in levels and types of activities and these were related in part to the particular local circumstances such as the existing organisation of services and the question of capital developments. The following section discusses the means by which the DMC/AMCs made decisions or agreed policies. Both the GP team member and DMC/AMC secretary questionnaires examined this topic since the perceptions of both these actors were considered important.

6.3 Patterns of Decision-making used by the District/Area Medical Committee

The District or Area Medical Committee (DMC/AMC) was designed for the purpose of providing broad advice from the full range of medical specialties working in the locality. The structure of membership implies that there are at least three groups with significantly different interests and that part of the committee's function will involve reconciling individual interests in deciding broad medical priorities. For this reason the following section concentrates on decision-making where these interests conflict or where different groups hold conflicting priorities. There is no doubt that much of the formal business of the DMC/AMC comprises of activities which cannot

be described as decision-making.[5] These include receiving items of information and discussing issues of technical concern where there is no apparent difference of interest. By focussing on areas where interests differ the survey focusses on what is the most important area of the DMC/AMC's purpose, at least in the view of the architects of the structure.

The first item to be considered is the basic decision-making rule of the DMC/AMC. The District or Area Management Team is governed by the rule of consensus on the grounds that no team member's views or the views of those he represents or manages should be over-ruled. This does not indicate unanimous consent but a situation where the decision must be minimally acceptable to each member (Schein, 1969). It is assumed that overruling the views of one team member is likely to result in policies that are difficult or impossible to implement. The DMC/AMC is not a management committee nor is it concerned with policy-making in the same sense, but it is designed to find agreements on contentious issues. Additionally in many issues the agreement of the doctors concerned may be necessary if implementation of policies is to take place since doctors exercise autonomy at the level of service delivery. Additionally many policies will have an oportunity-cost in the same or another sphere. For instance GP team member 025 argued that the DMC should be concerned with 'the distribution of funds between primary and secondary services'. This assumes that resources are scarce and can be deployed in different services.

Table 6.3 shows the criteria adopted by DMC/AMCs for making decisions. On aggregate DMCs and AMCs marginally favoured using consensus as the decision-making rule with 52% favouring consensus while 44% were satisfied with a majority vote. However, the DMCs favoured consensus (58%) and the AMCs favoured the majority vote (61%). The explanation may lie in the

structural differences between single-district areas and health districts. The AMC had a statutory obligation and right to advise the Area Health Authority (AHA) as well as the management team. It may then be under greater pressure to make decisions and unable or unwilling to fail to reach a decision on items where there is no consensus. The DMC may realise that it holds a weaker position and that advice which does not represent a consensus is of little value.

Undoubtedly a consensus decision is more valuable for both the DMC and the AMC (and indeed the authority) than a majority vote provided the DMC or AMC speaks for those doctors it is said to represent. It was argued above that the DMC/AMC may only be representative of the local doctors in a weak "microcosmic sense" in which case its legitimacy may be in doubt. There is no doubt that there are no widely acceptable principles upon which decisions concerning resource allocation can be made. Put differently there are no clear principles by which decisions can be made in a situation of scarce resources where not all "needs" can be met. A study of the allocation of growth monies between different services in two health boards in Scotland showed that the allocation process was far from rational (Hunter, 1980). Consequently the motivation to achieve consensus was strong and the means used were examined using a typology of means of resolving conflict.

From an analsis of the literature on committee decision-making a list of six potential tactics of coping with conflicting interests was developed.[6] These are listed below:;

Typology of Decision-making Tactics

(a) The chairman usually sees disagreement coming and manages to steer the committee around the issue.

(b) We avoid discussing issues that are likely to be contentious.

(c) We discuss the matter thoroughly and then come to a compromise decision.

(d) We agree to differ.

(e) We defer the decision for as long as possible to allow reconsideration.

(f) We take specialist advice and usually abide by that advice.[7]

The first strategy is usually the province of a strong chairman and although it suggests some degree of manipulation may be an important factor in a successful outcome. The second is perhaps realistic since it suggests that a consensus is important and failure to reach such a consensus may be damaging to the committee. The third strategy of compromise assumes that protagonists are prepared to move their positions sufficiently to produce an agreement which is satisfactory if not optimal. The fourth is the non-decision where members openly recognise that their differences are irreconcilable at a particular moment and so no decision is made. The fifth strategy might well be termed procrastination since it simply involves putting off the decision to a later date. The final option concerns the use of specialist advice and suggests that some of the issues which face the DMC/AMC are open to solutions of a technical nature which are acceptable to the membership.

None of these strategies is likely to be appropriate in all circumstances and therefore it might be expected that any particular DMC/AMC may use a combination of these methods to deal with different problems. It is also possible that different participants may view the treatment of a particular problem in different ways. For instance some participants may not recognise or think that certain items are systematically excluded from consideration as suggested in the second option, or that the Chairman steers the committee around certain issues or manipulates the decision-making process. Only two of the strategies resulted in immediate decision; the compromise and the specialist decision. The remaining options describe forms of non-decision in which the issue is for some reason ignored or deferred.

The DMC/AMC secretaries' sample was asked to indicate those strategies which they felt best described their committee. Respondents were free to choose as many categories as they wished. Table 6.4 shows that the most popular response was the compromise mentioned by 82% of the respondents. Two other strategies were chosen by a similar number of respondents one of which resulted in a decision and the other a "non-decision". In the DMC/AMC secretaries' sample 37% selected the "agree to differ" category and 35% the specialist decision. There was little difference between the DMC and AMC responses. The endorsement of the "agree to differ" strategy suggests that some DMC/AMCs openly confront contentious issues, albeit unsuccessfully on occasions. Selection of the specialist decision category suggests that in some cases DMC/AMC decisions are made on the basis of technical expertise although it is not clear what sort of expertise, for instance medical or administrative, is indicated.

The next feature about the way in which DMC/AMCs deal with conflict concerns the range of decision-making strategies used. By counting the number of strategies which the DMC/AMC secretaries selected a score is obtained although the precise meaning of such a score may say more about the respondent than the committee. This can only be met by the counter-objection that the DMC or AMC secretary is perhaps best placed to observe the way in which the committee operates. Table 6.5 shows the number of strategies identified by the respondent and the first point to note was that five DMC/AMC secretaries denied that the committee used any of the strategies at all. The three AMCs and two DMCs argued that the DMC or AMC did not meet any differences of opinion and therefore such strategies were unnecessary. This certainly questions the principles underlying the concept of a DMC/AMC with a particular balance of membership. It does fit in with the picture of the DMC/AMC as a passive reactive body taking few initiatives and treading on few toes. A further 32% of respondents mentioned

only one strategy, which was almost inevitably the compromise, and 21% mentioned three methods. Only three respondents identified four methods and it became clear that the three areas of decision-making identified were the compromise, agreeing to differ, and endorsing specialist decisions. It seems reasonable to argue that only those DMC/AMCs who are able to employ a variety of strategies in dealing with conflict are likely to be able to provide the sorts of advice which was envisaged in setting up the management system. It is important that these findings are interpreted in the light of the previous finding that 52% of DMC/AMCs were said to make decisions only by consensus, which implies that in some cases no decision was made.

A further question was included to identify the single strategy which DMC/AMC secretaries felt was most characteristic of their committee. Not surprisingly 75% selected the compromise strategy and one respondent was sufficiently brave to select the avoidance option (see Table 6.6). Approximately equal numbers chose the remaining options and this is only significant to the extent that they did not choose the compromise which is perhaps the most in keeping with administrative and professional dignity.[8]

In assessing these findings on decision-making strategies a few structural influences should be examined. Firstly it was possible for each of the categories of membership in the DMC/AMC to use other methods to achieve their objectives if these were blocked on the DMC/AMC. For instance the hospital doctors could act through the Medical Staff Committee or Medical Executive Committee which had direct access to the management team or the authority. Additionally the GPs could act through the Local Medical Committee and the Community Physicians had a hierarchical relationship with the District Community Physician or the Area Medical Officer. Secondly, the range of issues of interest to more than a minority of the membership of the DMC/AMC was limited and it was these issues which formed

the raison d'etre for its existence. Thirdly, if the DMC/AMC was to be effective it needed to come to consensus decisions since it provided nothing which was not already available to the team or authority from the relevant functional advisory body, such as the Local Medical Committee (LMC) and Medical Executive or Medical Staff Committee (MEC/MSC), unless it produced a broad medical consensus.

The following section examines the content of particular policies agreed by the DMC/AMC to examine the nature of those policies and the extent to which they comprise expectations.

6.4 The Content of District/Area Medical Committee Policies

The analysis of DMC/AMC policies is based largely on the answers to question 7 of the GP team member questionnaire: what are the main issues which the DMC/AMC wishes the District/Area Management Team to pursue? The responses are likely to show some degree of bias since the question was addressed to the GP clinical team member. It might be expected that the consultant team member would give slightly different answers but the focus of this study is upon the GP team member's perception of DMC/AMC policies.

The answers to the question were listed and read by the researcher and placed in a number of subject categories. No detailed statistical analysis is possible on this data but each of the items will be discussed and examples given. The significance of the issues is that they represent the GP team members' perceptions of the expectations that the DMC/AMC have of the management team.

In the first place it should be recognised that four GP team members felt that the DMC/AMC had not agreed on any issues that it wanted the management team to implement. A further GP team member reported that the consultant members had withdrawn their co-operation and therefore the DMC had lost its unique purpose within the district. The remainder of the

respondents identified one or more areas of policy on which the DMC/AMC had agreed. The first category concerns questions of hospital provision and includes issues of hospital facilities, district hospitals, GP hospitals, and the use of such premises. Altogether seven GP team members mentioned that the DMC/AMC had agreed policies on the question of new district general hospitals or major extensions to existing hospitals. Five mentioned that the DMC/AMC had agreed policies on GP hospitals which included the provision of new premises and the defence of existing GP hospitals against financial cuts. Respondent 003 mentioned that the DMC had agreed on policies concerning the organisation of work in a GP hospital. Such policies presumably required the co-operation of consultants as well as GPs and also a range of other non-medical staff groups.

The next category of policies can be subsumed under the heading of manpower; both medical and non-medical. Five respondents specifically mentioned efforts to obtain new consultant posts to rectify deficiencies in local services. For instance, GP team member 079 said that a second consultant in Obstetrics and Gynaecology was a DMC priority while respondent 103 mentioned that an Accident and Emergency consultant and department was the top priority. Both these instances concern consultant posts which the management team was not empowered to create alone. Agreement among the profession within the district was a very important step in the process of obtaining new posts.

A similar number of respondents mentioned the issue of the activity of practising GPs in part-time hospital appointments. Respondent 056 mentioned that there was agreement on the need to create more medical practitioner grade appointments. Such posts require close co-operation between the GP and consultant and this policy shows that the DMC/AMC tends to deal with issues that lie at the community-hospital interface where the

main groups of DMC/AMC members have shared interests. Four respondents mentioned the issue of community nursing and paramedical staff which also significantly affects the hospital-community interface and the ability of the primary care team to care for patient groups who might otherwise require hospital care.

The next category of issues identified concerned the distribution and redistribution of resources within the district. Two main sorts of policy stand out: the first concerned the balance of resources between primary and secondary services; the second identified individual priority groups or services to receive increased resources. An example of the first category was given by respondent 025,

> The DMC at its meeting yesterday felt that we should be concerning itself with examining the distribution of funds between primary and secondary services. This is difficult in a teaching district where much of the Regional and Sub-Regional specialties are concentrated.

While this DMC recognised a problem in resource distribution it had no solutions for the maldistribution. Other DMC/AMCs had identified resource priorities in geographical or patient-care terms. For instance GP respondent (004) reported,

> Better hospital facilities for Seatown and a more equitable distribution of the money to reverse the present system of Urban City having all the money.

An example of the definition of priorities in specialty terms was reported by GP team member 042 whose committee had decided on priorities for purchase of hospital equipment. Three respondents stated that their policies for redeployment resulted from "cuts" in resources. A further eight respondents identified particular services which were needed in the district including a dietetic service (GP team member 089) and a pain relief team (GP team member 054).

Priorities were also identified in terms of patient care groups and these resembled the government's priority groups. For instance, respondent 011 pointed to 'The improvement of community services and joint funded schemes for the elderly and mentally handicapped'. A similar response came from GP team member 085,

> More support in the community, especially in nursing staffs and in aids for the handicapped.

The degree of generality in these statements reflects the nature of the questionnaire and also the nature of policy-making in the DMC/AMC which appeared to operate at a high level of generality.

Fourteen respondents identified specific care-group issues as priorities identified and agreed by the DMC/AMC. Those mentioned most frequently were the elderly and the psychogeriatric groups. Respondent 077 replied that it had been agreed that the area should provide "geriatric beds up to the DHSS norm". This was an unusually specific policy since it suggested an outcome measure which could be used to see if the objective had been fulfilled.

The last main group of policies concerned the provision of services for patients by GPs and their access to district or area facilities. Six respondents identified the question of diagnostic tests and the transportation of samples and results between hospital and surgery. Respondent 063 highlighted,

> ... the development of clinical services e.g. outside the hospital area, e.g. ECG for GPs, maternity GP beds, code of practice, etc.

Similarly respondent 056 mentioned that a policy had been agreed by the DMC regarding the "collection of laboratory specimens from Health Centres and large practices". Another closely related set of issues concerned the access of GPs to facilities located in hospitals which was mentioned by eight respondents. For instance respondent 088 identified

the question of open access to district physiotherapy services. Most of these issues are primarily of interest to GPs and reinforce the point that the DMC/AMC is the only direct means which GPs have of influencing the services provided in the district.

The last issue of importance to a number of respondents was the question of waiting lists which was mentioned by 16 respondents. Considerable importance was placed upon the delays experienced in obtaining outpatient appointments particularly for urgent cases. For instance, respondent 040 mentioned,

> reduce waiting lists for outpatient clinics.
> Arrange a better appointments system for outpatients clinics.

While many respondents described DMC/AMC policies in highly general terms this respondent indicated scope for improvement in increased administrative efficiency. Other respondents pointed to "bottlenecks" in inpatient waiting lists for particular specialties in short supply locally.

To what extent can these responses be understood as DMC/AMC policies? Firstly the answers came from the GP team members and appear to be biased towards issues of particular interest to GPs. It is in the nature of the committee that issues must be of interest to more than one section of the membership and many of the policies identified fall into the primary care-hospital interface. Additionally the representatives of hospital doctors and community doctors have other means of pursuing their priorities through Medical Staff or Medical Executive Committees and directly to the team or authority. Additionally specialty interests can be pursued directly through the Specialist Sub-Committee system at the Regional level.

Three sorts of policy can be identified from the results reported above. The first category concerns new items of expenditure through

capital developments or new staff positions with the district. Both capital and manpower decisions have important consequences and are decisions made at higher levels in the NHS but local agreement is an important step in the policy-making process. The second category of policies imply reallocation of existing resources or new packages of care using those resources. These frequently emphasised particular care-groups or services. The third group of policies concern the co-ordination of hospital and community services including questions such as waiting-lists and GP access to diagnostic and treatment services.

These policies have different implications for the GP team member and the management team. The first category of "new developments" imply increased resources which could not be assumed during the period under study. The second category of "reallocation" implied that the total of resources remained constant and new services required savings from, or loss of, existing services. The third category of co-ordination was frequently described in terms of efficiency or improved administrative systems but often meant that existing means of controlling the use of beds or diagnostic services would be circumvented. For instance GP access to diagnostic tests might result in increased use of these tests and have implications for budgetary control of the particular service. Thus few policies had no resource implications and many involved competition for scarce resources within the district or area and were therefore not likely to be undertaken lightly by a management team.

6.5 The Specification of District/Area Medical Committee Expectations

An important element of the DMC/AMC's activity in the creation of expectations is the formal specification of policies and the distribution of minutes and reports. These papers may act as formal expectations and also as a source of information for other committees or individuals. It

was first ascertained that all District and Area Medical Committees produced minutes from the DMC/AMC secretary. Then the respondents were asked to whom the DMC/AMC minutes were distributed and the results are shown in Table 6.7.

The first two categories of recipient of DMC/AMC minutes were the management team and the health authority, the bodies the committee was set up to advise. (The DMT and AMT are included in the same category although a separate category was necessary for the Area Team of Officers (ATO) in a multi-district area.) The first finding is that while 90% of DMCs sent their minutes to the DMT only 50% of AMCs sent their minutes to the AMT. Two-thirds of the AMCs sent their minutes directly to the Area Health Authority. It cannot be concluded that the AMT are unaware of AMC views and policies but indicates that the AMC has a close formal relationship with the Area Health Authority which is not the case amongst DMCs of which only 13% sent their minutes to the authority. This is not surprising since most Areas with health districts also had an Area Medical Committee to advise them and a close relationship might be expected between the DMC and the corresponding AMC.

Since the chairman and vice-chairman of the DMC/AMC were also members of the DMT/AMT it could be expected that they would inform the team about those issues where the committee had strong views. It does however place the whole responsibility upon the clinical team members in the 10% of districts and 50% (9) areas where minutes were not routinely sent to the team. It was noted above that DMCs received minutes from the DMT in 48% of cases and the corresponding finding for AMCs was 33%.[9] Thus the clinical team members play an important part in mediating the relationship between the medical advisory committee and the management team. Additionally the clinical team member has the opportunity to control the flow of information between management team and medical committee in some cases.

The next category of committees to which some DMC/AMCs distributed their minutes were the representative bodies for GPs and hospital doctors, the Local Medical Committee (LMC) and the Medical Staff or Medical Executive Committee (MSC/MEC) respectively. Table 6.7 shows that the DMCs sent minutes to the LMC or MSC/MEC in about 30% of cases. The AMC sent minutes to the LMC in 28% of cases and the MSC/MEC in 50% of cases. Thus, in most cases the DMC did not formally inform the LMC or the MSC/MEC of its activities. Again, there was likely to be cross-membership between the committees and informal exchange of information. The reasons for this lack of formal communication may be varied. Firstly the MSC/MEC is centred upon the hospital, meets more frequently than the DMC/AMC and has the right of direct access to the management team. Additionally, like the LMC, it is concerned with issues relating to different boundaries, whether they are the county (in the case of many LMCs), or the hospital.

Some DMC/AMCs recognised the position of GPs within a health district or area and sent copies of their minutes directly to the GPs since there was no forum concerned directly with local interests among GPs. This occurred in 20% of cases and may be significant in facilitating GP interest and action within the representative process.

DMC/AMC minutes fulfil at least two functions; they act to increase visibility among actors within the role-set and they also form an objective, if not necessarily accurate, picture of the committee's policy decisions.[10] They may therefore act as formal expectations between the committee and the team or authority to which they are sent. The main bodies to which the DMC/AMC minutes provide information, or increase visibility, are the LMC and the MEC/MSC. To a lesser extent they provided information to the GPs within a district or area as well. The minutes also provide evidence of the result of previous expectations sent by the LMC, MEC/MSC or

individual GPs. The purpose of sending expectations to the DMC/AMC must be to enlist wide-ranging support for a proposal and receipt of the minutes may show the extent to which this support has been achieved.

The DMC/AMC minutes may also give some indication of those matters on the policy-making "agenda" over which consultation is taking place or where developments are possible. The advice produced is presented through the clinical team members to the management team and therefore it may be important for the DMC/AMC to have some method of ensuring accountability. This is discussed in the next section.

6.6 Accountability in the Representative Process

To the extent that the DMC/AMC regard their policies as expectations it might be expected that the committee will undertake various forms of activity to increase the probability that the DMT/AMT will act on these expectations. It was suggested above that the experience of previous expectations, as perceived by the sender, would affect the form of future expectations.[11] These views about the representative process suggest that the representative's action in transmitting or carrying expectations from the DMC/AMC to the management team will be of primary importance to the committee.

Firstly the DMC/AMC may be expected to select clinical team members who are both competent and reliable. The evidence presented in chapter 5 suggested that the GP team members tended to have considerable experience of committee activity in the NHS. Many had been selected at the 1974 reorganisation and served continuously from then.[12] The selection mechanisms frequently involved widespread consultation with the Local Medical Committee and other influential bodies.

Secondly the DMC/AMC may adopt procedures to review the progress of items of business and agreed policies and therefore make the clinical team members accountable for their actions. The DMC/AMC secretaries were asked how frequently the committee reviewed progress on such items. Not surprisingly 62% of respondents claimed that the DMC/AMC frequently reviewed progress and 22% chose the sometimes category (Table 6.8). The most obvious means of reviewing issues is through the "matters arising" section of an agenda but it should be remembered that 27% met only quarterly or less frequently and a further 29% met every two months (see Table 5.23). In such committees the extent of monitoring is likely to be small.

While the DMC/AMC cannot, in most cases, review progress on every item for which a medical view is sought; it can review progress on significant, ongoing items. These might include the commissioning of a new hospital or changes in the "package of services" provided within a particular district. Consequently the GP team member must be given a large degree of autonomy to act on behalf of his colleagues. The chief means of formal accountability is the extent to which the GP team member reports on his activities to the DMC/AMC. The DMC/AMC secretary questionnaire included the question; How often do the clinical members of the DMT/AMT report on DMT/AMT activities to the DMC/AMC and what form does it take? The question was "closed" and the options included spoken and written reports since it was thought that written reports indicated more rigorous forms of accountability than the spoken variety. Seventy per cent of DMC/AMC secretaries reported that the clinical team members never or seldom made written reports and only 24% frequently or sometimes made such reports (Table 6.9). In contrast 69% of team members frequently made spoken reports and only 10% seldom or never made such reports. As a check the same question was addressed to the GP team member and similar results

were obtained (Table 6.10). While GP team members claimed to make written reports slightly more frequently than reported by the DMC/AMC secretary the findings for spoken reports were similar. Table 6.11 shows similar findings between DMT and AMT GPs for the provision of written reports to the DMC or AMC.

Thus the reports of the team member are not formally recorded except to the extent that accounts may appear in the DMC/AMC minutes. This may support the view that the DMC/AMC is only able to brief the team members in a general way on the more important issues, again leaving substantial areas of autonomy particularly on questions of detailed planning and management. The District/Area Administrator survey suggested that the DMT/AMT may have another record of the DMC/AMC's views in the 65% of districts and areas whose teams received such minutes (Table 10.1). It is unlikely that such minutes form an independent view of DMC/AMC expectations since the chairman and vice-chairman of the DMC/AMC, also the team members, played such an important role in the creation of agendas and production of policy.

Evidence suggests that accountability is limited to important issues of concern to the DMC/AMC issues with large capital or revenue implications. There is wide scope for discretion on the part of the team member over less significant issues and there are no mechanisms, in most DMC/AMCs, for detailed monitoring of the activity of the team member.

Table 6.1 Committees where minutes are included in agendas for the district/area medical committee

(percentages in brackets).

Committee	District Medical Committee		Area Medical Committee		Total	
Family Practitioner Committee	3	(4.84)	1	(5.5)	4	(5)
Local Medical Committee	18	(29.03)	6	(33.3)	24	(30.0)
Health Care Planning Team	16	(25.80)	2	(11.1)	18	(22.5)
Cogwheel Divisions/MEC	12	(19.35)	3	(16.6)	15	(18.75)
District/Area Management Team	30	(48.38)	6	(33.3)	36	(45.0)
Community Health Council	1	(1.61)	1	(5.5)	2	(2.5)
Other	23	(37.09)	8	(44.4)	31	(38.75)
Total	62	(100)	18	(100)	80	(100)

District Medical Committee question 13.

Table 6.2 Whether district/area medical committee had arrived at agreed policies?

(percentages in brackets).

	District Medical Committee		Area Medical Committee		Total	
No Answer	-		1	(7.1)	1	(1.12)
Yes	55	(73.3)	6	(42.8)	61	(68.5)
No	16	(21.3)	7	(49.9)	23	(25.8)
DMC Suspended	4	(5.3)	-		4	(4.49)
Total	75	(100)	14	(100)	89	(100)

percentages total downwards.

GP team member question 6.

Table 6.3 Decision-making rule used by district/area medical committee

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	1	(1.61)	1	(5.5)	2	(2.5)
Consensus only	36	(58.06)	6	(33.3)	42	(52.5)
Majority Vote	24	(38.71)	11	(61.1)	35	(43.75)
Other	1	(1.61)	-		1	(1.25)
Total	62	(100)	18	(100)	80	(100)

Percentages calculated downwards

District Medical Committee question 14.

Table 6.4 Methods of dealing with conflict used by district/area medical committee

(percentages in brackets).

Method	District Medical Committee		Area Medical Committee		Total	
Steer Around	7	(11.29)	2	(11.1)	9	(11.25)
Avoid Issue	-		2	(11.1)	2	(2.5)
Find Compromise	52	(83.8)	14	(77.7)	66	(82.5)
Agree to Differ	25	(40.32)	5	(27.7)	30	(37.5)
Defer Issue	11	(17.7)	2	(11.1)	13	(16.25)
Abide by Specialist Decision	21	(33.87)	7	(38.8)	28	(35.0)
Total	62	(100)	18	(100)	80	(100)

District Medical Committee question 15.

Table 6.5 Number of methods which district/area medical committee uses to deal with conflict

(percentages in brackets)

Number of Methods Used	District Medical Committee		Area Medical Committee		Total	
0	2	(3.2)	3	(16.6)	5	(6.25)
1	21	(33.8)	5	(27.7)	26	(32.5)
2	23	(37.09)	6	(33.3)	29	(36.25)
3	13	(20.96)	4	(22.2)	17	(21.25)
4	3	(4.83)	-		3	(3.75)
5	-		-		-	
Total	62	(100)	18	(100)	80	(100)

percentages calculated downwards.

District Medical Committee question 15.

Table 6.6 Method of resolving conflict most characteristic of district/area medical committee

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	1	(1.6)	1	(5.5)	2	(2.5)
Steer Around	3	(4.8)	1	(5.5)	4	(5.0)
Avoid Issue	1	(1.6)	-		1	(1.25)
Final Compromise	46	(74.2)	14	(77.7)	60	(75.0)
Agree to Differ	3	(4.8)	-		3	(3.75)
Defer Issue	2	(3.2)	1	(5.5)	3	(3.75)
Abide by Specialist Decision	3	(4.8)	1	(5.5)	4	(6.0)
Multiple Strategies	3	(4.8)	-		3	(3.75)
Total	62	(100)	18	(100)	80	(100)

Percentages calculated downwards.

District Medical Committee question 16.

Table 6.7 Bodies to which district/area medical committee minutes are distributed

(percentages in brackets)

Committee or Team	District Medical Committee		Area Medical Committee		Total	
District/Area Management Team	56	(90.3)	9	(50.0)	65	(81.2)
Area Health Authority	8	(12.9)	12	(66.6)	20	(25.0)
Area Team of Officers	10	(16.1)	-		10	(12.5)
Local GPs	14	(22.6)	3	(16.6)	17	(21.2)
Medical Executive/ Staff Committee	20	(32.3)	9	(50.0)	29	(36.2)
Family Practitioner Committee	5	(8.1)	4	(22.2)	9	(11.2)
Local Medical Committee	19	(30.6)	5	(27.7)	24	(30.0)
Community Health Council	4	(6.5)	3	(16.6)	7	(8.75)
Others	26	(41.1)	9	(50.0)	35	(43.75)
Total	62	(100)	18	(100)	80	(100)

District Medical Committee questions 17 and 18.

Table 6.8 Frequency that the district/area medical committee reviews progress on policy implementation

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	1	(1.6)	1	(5.5)	2	(2.5)
Frequently	40	(64.5)	10	(55.5)	50	(62.5)
Sometimes	15	(24.19)	3	(16.6)	18	(22.5)
Seldom	2	(3.2)	2	(11.1)	4	(5)
Never	-		1	(5.5)	1	(1.25)
Not Applicable	4	(6.45)	1	(5.5)	5	(6.25)
Total	62	(100)	18	(100)	80	(100)

Percentages calculated downwards.

District Medical Committee question 20.

Table 6.9 Frequency that GP team members make written and spoken reports of management team activity to the district/area medical committee

(percentages in brackets)

	Written Reports		Spoken Reports	
Frequently	6	(7.5)	55	(68.75)
Sometimes	13	(16.25)	17	(21.25)
Seldom	5	(6.25)	4	(5.0)
Never	52	(65.0)	-	
Not Applicable	4	(5.0)	4	(5.0)
Total	80	(100)	80	(100)

Percentages calculated downwards.

District Medical Committee question 24.

Table 6.10 Frequency that GP team members report making written and spoken reports of management team activity to the district/area medical committee

(percentages in brackets)

	Written Reports		Spoken Reports	
No Answer	2	(2.25)	1	(1.12)
Frequently	10	(11.23)	62	(69.66)
Sometimes	11	(12.35)	16	(17.97)
Seldom	12	(13.48)	4	(4.49)
Never	50	(56.18)	2	(2.25)
Not Applicable	4	(4.49)	4	(4.49)
Total	89	(100)	89	(100)

Percentages calculated downwards.

GP team member question 8.

Table 6.11 Frequency that GP team members report making written reports to district/area medical committee

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	1	(1.3)	1	(7.1)	2	(2.24)
Frequently	8	(10.6)	2	(14.3)	10	(10.2)
Sometimes	11	(14.6)	-		11	(12.35)
Seldom	11	(14.6)	1	(7.1)	12	(13.48)
Never	40	(53.3)	10	(71.4)	50	(56.18)
Not Applicable	4	(5.3)	-		4	(4.49)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 8.

CHAPTER 7

THE LOCAL MEDICAL COMMITTEE - A CONSTITUENCY BODY FOR GPs?

7.1 Introduction

In 1948 the position of GPs as independent contractors was protected by the creation of Local Executive Councils which held their contracts. Separated from the services provided by Local Government on one hand and the hospital service on the other, the independence of GPs was established. The Local Medical Committee (LMC) dated back to 1911 and was set up to pursue the interests of GPs under the National Insurance Scheme. The LMCs continued to function in association with the new Local Executive Councils created with the National Health Service in 1948. The Department of Health and Social Security (DHSS) recognised the General Medical Services Committee (GMSC) as the 'mouthpiece' for GPs in the NHS and the GMSC was directly related to the LMCs at the local level. The membership of the LMC is composed of GPs elected on a constituency basis by their peers. Consequently the LMC has achieved a legitimacy amongst GPs which is unmatched by more recent bodies such as the District/Area Medical Committees (DMC/AMC) and local 'GP Forums' or Councils.

The LMC adopted various functions reminiscent of trade unions and friendly societies. The LMC would support a GP at a disciplinary committee of the Local Executive Council (LEC) facing a complaint concerning his observance of the conditions of his contract. For instance, failure to make a home visit when requested could constitute a complaint which the LEC disciplinary committee might hear. Additionally the LMC took a voluntary levy of GPs which was used to support dependents of sick doctors or their widows and orphans.

In 1974 the Local Executive Councils were reconstituted under the name of Family Practitioner Committees (FPC) and they retained most of their old functions. The FPCs were nominally attached to Area Health Authorities but

they retained a good degree of independence. In the 1982 restructuring of the service the FPCs were granted separate authority status but they remain largely 'pay and rations' authorities. During this period the LMCs have exhibited a degree of continuity which has been rare in the NHS. Some LMCs saw new opportunities in the 1974 reorganisation of the NHS to pursue the interests of GPs and their patients by endeavouring to build a close relationship with authorities and management teams in the new structure. Many however continued with little change in their activities since the reorganisation did not include independent contractor services.

An indicator of continuity is demonstrated in Table 7.1 which shows the date at which respondents to the LMC secretary survey had taken up their positions. It shows that 28% of the respondents had become secretary of the LMC in 1973 or before and that the reorganisation of the NHS in 1974 did not result in the sorts of unheaval experienced elsewhere in the NHS where there was widespread competition for the new posts. There were significant changes in LMC secretaries in 1977 and 1979 in addition to those in 1974. Indeed 1977 showed the largest number of changes in LMC secretaries. This aspect of continuity was unusual in the turbulent NHS.

The LMC was not formally recognised in the medical advisory machinery devised for the NHS at area and district and set out in the Health Circular and the Grey Book (HRC(74)9, DHSS, 1972, chapter 4). The multi-disciplinary advisory committee was the preferred alternative and this was discussed above in chapter 6 on the DMC and AMC, in which the two most important sections represented in the membership were the hospital doctors and the GPs. In contrast the LMC represented doctors of a single practice orientation namely independent contractors. The LMC also included members of the ophthalmic and pharmaceutical professions although this aspect of their work is sufficiently minor to ignore for the purposes of this discussion. The LMC also includes specialist advisers such as consultants and community

physicians, who are paid a retainer for their services but whose work is essentially advisory.

The LMC is distinctive in the NHS because of its continuity and the standard pattern with which it operates throughout England and Wales. It is the only body which is recognised both locally by GPs and, through its relationship to the General Medical Services Committee, by the DHSS as the mouthpiece for GP views. It is particularly important since the nature of general practice is that partnerships and practices are independent both in structural and spatial or geographical terms. Consequently GPs share many interests with other GPs, regardless of the question of NHS district or area boundaries, which LMCs pursue collectively. For instance, the question of remuneration and the scales of fees which are decided nationally and implemented locally are a matter of concern to GPs in different parts of the country.

LMCs have also acted as advocates for GPs' interests locally and are recognised by many GPs as the natural focus of these interests. It was therefore important to examine the extent to which the LMC acted as a constituent body on behalf of the GPs it represented. One aspect of the relationship of LMCs and local health services was that LMCs operated at the Area level of NHS administration and were therefore not coterminous with health districts. It might be expected that the LMC would more easily act as a constituency body for GPs within a single-district area than for those in a multi-district area. Throughout this chapter the distinction is noted between coterminous LMCs and those which cover more than one management team at the operational level of service provision.

7.2 The Significance of Structural Features

The administrative arrangements adopted by the LMC depend upon the characteristics of its 'constituency' and, incidentally, its level of income

since the LMC is financed directly by GPs. The number of GPs in an area might vary considerably owing to the demographic characteristics, the size of the area, and the nature of the NHS services provided in that area. Table 7.2 shows that only 22% of the sample employed a full-time secretary and these included only four LMCs in single-district areas. For 65% of the sample of LMC secretaries the job entailed not more than ten hours work each week. Table 7.3 shows that the majority of LMC secretaries (75%) had medical qualifications and that a further 18% were previously FPC or NHS administrators.[1] A further three LMCs had as their secretaries a retired DHSS Regional Medical Officer - the officer responsible for monitoring the prescribing of drugs by GPs. Thus LMC secretaries were primarily selected from among GPs but included others with relevant administrative experience, usually in the NHS. The LMC secretaries were supported by clerical staff assisting in the administration of the committee.

A clearer view of the work of the LMC secretary is shown in Table 7.2 which show that 42% of respondents claimed to work up to five hours per week on LMC business while 22% worked full-time, usually for more than one LMC. Those secretaries from LMCs in single-district areas were likely to work shorter hours suggesting the size of the task and the available resources were less. The arrangements for LMCs in the London area were distinctive since one secretariat served 11 LMCs. This included three full-time, medically qualified secretaries and their supporting staff. It is possible that such an arrangement has important implications for co-ordinating the work of LMCs in London.

The level of activity of the LMC is a significant aspect of the policy-making process. Table 7.4 shows an important similarity between LMCs in single and multi-district areas. Sixty per cent of LMCs met monthly and a further 26% met every two months. Some LMCs mentioned that a standing or executive committee operated between main meetings which may have affected

the pattern and the frequently of formal meetings. The degree of similarity between LMCs in the pattern of formal meetings may reflect the structure of interests among GPs which is largely independent of purely local interests. Thus many items of interest to GPs are decided at the national level and therefore require the concerted action of LMCs and the General Medical Services Committee. Additionally the pattern of activity of the GMSC requires that formal propositions be agreed locally and then sent to the national committee and therefore formal meetings are necessary.

The creation of the LMC agenda was the responsibility of the secretary, assisted by the chairman in some cases (Table 7.5). The pattern was similar for LMCs in single and multi-district areas when the finding for those LMCs serviced by the London secretariat is added to the secretary category.[2] As the paid servant of the committee this finding is in keeping with the previous finding that 75% of LMC secretaries were medically qualified (Table 7.3).

The LMC secretaries were asked to estimate how frequently the chairman, members and themselves contributed items to the LMC agenda. Eighty-two per cent of secretaries claimed that they frequently contributed items to the agenda (Table 7.6). Only 42% of chairmen and 19% of LMC memberships frequently raised items for the agenda. The LMC secretaries estimated that 49% of chairmen and 73% of memberships sometimes raised questions for the agenda. This finding compares favourably with the corresponding finding for the contribution of members of the DMC and AMC to the agendas. This is largely explained because the LMC is composed of a membership who share a single practice orientation. It follows that they share a wider range of interests than the members of a DMC or AMC who operate according to at least three practice orientations and are frequently concerned with issues at the interface of hospital, community and GP services. This supposition is

borne out by a finding from the survey of practising GPs which identified the most important forum for the pursuit of GPs' interests as the LMC (see Table 8.7). Secondly, the LMC has a permanent office and staff which may facilitate contact between members and the LMC. Thirdly the LMC has an established position which enables it to negotiate with the Family Practitioner Committee on behalf of GPs.

These findings were supported by evidence obtained for the Royal Commission on the NHS by Professor Kogan's team and published in the first working paper. In paragraph 18 it stated,

> 'there were few comments on the LMCs except to express satisfaction on their functioning'.
>
> (Royal Commission, 1978, para. 8.18).

The paragraph also suggested that the situation of the LMC at area level may divert the interest of GPs away from district matters. Since April 1982 many LMCs have operated in conjunction with several health districts and the removal of the area tier may have added to this disjunction of interests.

The receipt of minutes by the LMC indicates the extent of the formal relationships which exist with other professional and administrative committees. Table 7.7 shows that for LMCs in single and multi-district areas the most frequent source of minutes was the Family Practitioner Committee (FPC). It is notable that less than half of the LMCs received FPC minutes. It may be the case that most LMCs have one or more members who also belong to the FPC.[3] Such 'cross-membership' suggests that informal links may be more important than formal links in facilitating the relationship between LMC and FPC.

The LMCs did not receive minutes or reports from the appropriate management teams (i.e. DMTs or AMTs) in more than 30% of cases. This

follows the pattern of relationships outlined in the Grey Book in which the key relationship was that between the local advisory committee and the management team. About half of the LMCs in single and in multi-district areas received minutes from the Area or District Medical Committee and 43% of LMCs in multi-district areas received minutes from the Area Medical Committee. It follows that the LMCs in single-district areas were not more likely than their counterparts in multi-district areas to receive minutes from the medical advisory committee but that half of the responding LMCs in both categories did not receive such reports. Additionally when advice is needed regarding important developments in the GP or hospital services, patterns of formal or informal consultation may be used which involve the DMC/AMC, LMC, and Medical Staff or Medical Executive Committees.

About 30% of LMCs received minutes from the Area Health Authority (AHA) and this was more frequent in LMCs in single-district areas (38%) than in those LMCs covering several districts (26%) which was surprising since both operate at the same level and cover similar populations. The other important source of minutes mentioned by respondents was the General Medical Services Committee (GMSC) at national level. This emphasises the relative homogeneity of GPs, unlike hospital specialists, whose practice organisation differs in partnership size and the disposition of other staff but who retain close interests resulting from the practice orientation and the common 'specialty'. It is notable that more than a quarter of LMCs received minutes from the DMT or AMT which suggests a formal relationship and the ability of the LMC to monitor team activities to some extent. It should be remembered however that the majority of LMCs did not receive such minutes but may have used informal means of monitoring team activity. It was noted in chapter five that 81% of GP team members were also members of the LMC (see Table 5.5). The following section deals with the process of policy making adopted by the LMC.[4]

7.3 The LMC and Policy Making

Before examining the means by which the LMC makes decisions it is important to bear in mind its nature and functions. As a committee of elected GPs, its objectives are relatively clear as are the interests of those it represents. It is not a multi-specialty committee charged with reconciling the views of different intra-professional groups and those doctors other than GPs who attend the LMC do so as advisers, not as members. Therefore the arguments which suggested that the DMC/AMC should operate by consensus, namely to resolve inter-specialty conflict and provide medical views, do not figure in this case. The LMC can operate by majority vote since that does not imply that any particular specialist group is dictated to by members of other specialist groups. In consequence it might be expected that the LMC will find the resolution or avoidance of conflict less problematic than the DMC/AMC.

Table 7.8 shows that LMC secretaries reported using a range of strategies for dealing with conflict although 5% denied that there was any conflict of views at the committee. A further third of the respondents mentioned just one method while 42% identified two. Table 7.9 shows that the most important means of dealing with conflict was to find a compromise after examining each point of view. One third of the LMC secretaries mentioned that the committees agreed to differ on some occasions when agreement appeared not to be forthcoming and a further quarter mentioned that the chairman steered the committee around the issue. The major difference between respondents in multi- and single-district areas was that the latter gave greater importance to the specialist decision than the former. Thus 32% of LMCs in single-district areas mentioned the option and the corresponding figure for the multi-district areas was 12%.

Table 7.10 shows that the method which most LMC secretaries identified as characteristic of their committees was the compromise decision although

10% pointed to the option of agreeing to differ as most appropriate. There was broad agreement between the secretaries of LMCs over this question regardless of the question of coterminosity with district or area management teams. No LMC mentioned the specialist decision as characteristic and this is in keeping with the nature of business conducted by the LMC and the structure of members' interests.

7.4 The Output of LMC Policy

One sign of the extent to which the Local Medical Committee (LMC) acts as a constituency body on behalf of GPs is the means by which it creates relevant policies and transmits them to the GP team member or to the team through formal mechanisms. As records of LMC decisions and agreed policies the minutes may act as formal expectations directed at a number of different bodies and committees. The LMC secretaries were therefore asked to which committees they sent copies of LMC minutes.

The most important target identified was the Family Practitioner Committee to which 53% of LMCs in multi-district areas but only 18% in single-district areas sent their minutes (Table 7.11). This inconsistency may be due to the nature and size of single-district areas and a predominance of informal relationships over formal ones. The size of a single-district area may mean that with correspondingly few GPs there is a considerable degree of cross-representation between the main professional and advisory committees. This may mean that the views of another committee are readily available to any particular committee thus easing the process of consultation. Additionally delays in preparation, distribution and digestion of minutes may be avoided and therefore enabling important issues to be pursued more quickly by informal means and relationships.

Only 29% of LMCs sent minutes to the appropriate DMCs and 18% in single-district areas to the AMC. Thus the majority of DMC/AMCs do not

have access to LMC minutes and depend upon cross-membership or explicit consultation for the views of the committee. Almost a quarter of LMCs in multi-district health authorities sent their minutes to the Area Health Authority and this may be a response to the range of advisory committees in such areas. It may also imply recognition of the importance of the AHA in strategic planning and management. It has been suggested that the AMC may compete with the DMCs for the attention of practitioners and doctors in such districts with the plausible result that one tier of advisory machinery fails to operate effectively.[5] In such cases the AMC may be superseded for advice by the DMCs and the appropriate GP and hospital doctor committees, the LMC and the Medical Staff or Executive Committee. One example of this duplication of function occurred in a two-district area in which the AHA was advised by the two DMCs and there was no AMC.

The formal relationships between the LMC and the management and advisory bodies within the health authority are not sufficient to justify the argument that the committee acts as a constituency body on behalf of the GPs it represents. The evidence about informal mechanisms such as cross-membership and the views expressed by GP team members and the sample of GPs suggests that the LMC is the most important forum for representing GP interests both locally and nationally. Another instance of formal mechanisms is the creation of district sub-committees in some LMCs and this is discussed in the next section.[6]

7.5 The LMC in Multi-District Areas

In response to the creation of relatively autonomous districts in the 1974 Reorganisation, some LMCs created district sub-committees. They were frequently composed of the elected LMC members for constituencies which fell within the boundaries of a particular health district. Such

sub-committees enabled the LMC to monitor the activity of the management team and by implication the GP member. They could attempt to ensure that the management team did not follow policies inimical to the LMC, local GPs, or more positively attempt to pursue more active goals through the DMT/AMT.[7]

Of the 49 LMCs in responding multi-district areas 21 (43%) had district sub-committees and 28 (57%) did not. As the LMC has its own system of electoral constituencies the secretaries were asked whether the district sub-committees covered the same boundaries as the health districts. Three LMCs had a separate system of sub-committees and the remainder (18) shared similar boundaries (Table 7.12). Further questions were addressed to discover the nature of activities characteristic to the sub-committees. Table 5.20 shows that 16 committees met at least quarterly but 5 met on an ad hoc basis or annually. Additionally 18 of the 21 claimed to make a regular, at least annual, report to the LMC of its activities or conclusions (Table 5.22). Twelve of the committees produced a written report and the remaining six reported verbally as appropriate (Table 7.12A). The general pattern suggested that a report was made to the main committee after each meeting of the district sub-committee.

The evidence did not suggest that LMCs with large numbers of health districts were significantly more likely to have district sub-committees than those with only two districts or that those sub-committees were likely to be more active or effective. One LMC had adopted a pattern in which the full LMC met quarterly and the district sub-committees met monthly. This was abnormal but suggested that the LMC gave a particular significance to the activities within the health districts.

All but one of the LMCs with district sub-committees claimed that the GP team member belonged to these committees and the exception included the GP team member in two of the three committees. Thus in about half of the LMCs with health districts there was a district sub-committee which included the GP team member. This informal relationship demonstrates that some LMCs placed an importance upon the activity of DMTs and made attempts to cope with the structural problems in a multi-district area.

The district sub-committee of the LMC provided GP team members with a small committee of district GPs elected by their colleagues to the main committee and available for consultation. The function of the committee varied between regular monitoring of district developments and a residual reference group or pressure group to advise and assist on exceptional issues of concern to GPs. This provided an alternative to relying upon the team members' intuition or undertaking the canvassing activities referred to on page 283.

7.6 A Constituency Body for GPs - Medical Advisory Committee or Local Medical Committee

The organisation of general practice is such that many factors act against GPs forming an important constituency interest group within the district or area. The spatial distribution of GPs and their practice organisation conspire with the administration of family practice to promote relatively isolated units of practice structurally and often geographically as well. The purpose of this section is to assess the claims of the DMC/AMC and the LMC to act as a proxy constituency or 'constituency body' in relation to matters of local management and administration of health services which are the responsibility of the authority or its management teams.

It may appear strange to compare the role of the DMC/AMC and the LMC given their different origins and functions within the NHS. This however is necessary since there is no other widespread representative body claiming to speak for GPs at the local level apart from the LMC. In contrast hospital doctors are represented by widespread patterns of Cogwheel, Medical Staff and Medical Executive Committees facilitated by the concentration of work on relatively limited number of sites and the close proximity of related specialties in many cases. The differences between the functions of each of these committee types (i.e. the DMC/AMC and LMC) are examined in the following pages.

Differences between the DMC/AMC and the LMC can be identified related to purpose, sutructure and style. These points have been discussed earlier but it is worth pointing out that the differences in purpose - namely providing single specialty advice to the FPC on the part of the LMC, and providing multi-specialty advice to the health authority or management team - underly the differences in structure of membership and style of activity. The characteristic membership of the two types of committee has been discussed above (see page 133) but the survey findings show that 70% of DMC/AMCs were administered by lay secretaries while 75% of LMCs had a medically qualified secretary - usually a GP (see Table 7.13). This highlights the fact that the LMC is a committee of GPs and largely run by GPs while the DMC/AMC is a creation of administrative reorganisation and usually serviced by the local NHS administration. The formal purposes of the two committees reflect these differences since the LMC gives single specialty advice while the DMC/AMC is designed to give advice not biased to one particular section of the profession.

There are also differences in style between the two committees which are illustrated by some of the following variables. Creation of the formal

agenda is a vital element in the functioning of a representative committee. Table 7.14 contrasts the role of chairman and memberships of DMC/AMCs and LMCs in contributing to the agendas of the committee. The survey response suggested that in both committees the chairman contributed to the agenda relatively frequently which would be expected since the chairman of DMC/AMC is usually a member of the management team and chairman of the LMC is regarded as an important role among GPs. However while the membership of the LMCs was reported to contribute items 'frequently' or 'sometimes' in 93% of cases, the corresponding figure for DMC/AMCs was 46%. Perhaps more notable was the fact that 52% of DMC/AMC secretaries replied that the membership seldom or never raised issues for inclusion on the agenda. This does not prove that DMC/AMC memberships are passive and reactive while LMC memberships play a more active initiating role. Rather the LMC is a single-specialty committee and it is at this level that one might expect GPs to raise issues of concern while the DMC/AMC is concerned with co-ordinating the views of different specialties and different sections of the profession. Nonetheless GPs are seen to raise issues of concern at the LMC and observation at LMC meetings would suggest that they see it as the focus of their interests in the first stages. As an advisory committee the DMC/AMC will be engaged in responding to proposals from various levels of management in the NHS and therefore much of its agenda will come from various levels of management as well as the issues originating from specialist advisory and professional committees.

The focus of this section is upon whether the DMC/AMC and the LMC can be understood as constituency bodies which act on behalf of GPs and it is clear that the LMC style involves greater participation from members in agenda creation than is the case in the DMC/AMC which is regarded as a constituency body for all the doctors in a district in the formal design of the structure but not necessarily by the participants.

Another important item in the agendas of DMC/AMC and LMCs is the minutes of other committees and teams. This formal relationship allows the passing on of important information about the 'policy agenda' and may be one way in which the activity of various bodies can be monitored. Table 7.15 shows that half of the LMCs included DMC/AMC minutes in their agendas and therefore had some idea of the formal activity of the DMC/AMC. Only 30% of DMC/AMCs included LMC minutes and this may indicate a one-sided aspect to the relationship between DMC/AMCs and LMCs in which the LMC is interested in the DMC/AMC since it is the only formal advisory committee in many districts/areas with substantial GP membership. Since the LMC is concerned with a wide range of issues the DMC/AMC may find much of its agenda irrelevant and therefore not receive formal minutes although there is usually cross-membership between the two committees.

As would be expected the DMC/AMC received management team minutes in 45% of cases and the LMC received FPC minutes in 43% of cases. The relationships between LMC and FPC are clearly very important and it is interesting that in half of the responses in both cases the minutes were not received. Twenty-eight per cent of LMCs received minutes from the management team and this emphasises a relationship of increasing importance as far as many LMC secretaries were concerned. The important formal relationship for the LMC was with the FPC and the corresponding relationship for the DMC/AMC was with the management team. However many LMCs displayed an important interest in the activity of the DMC/AMC and the appropriate management team which reinforced the view expressed by LMC secretaries that the LMC was beginning to take an increasing interest in the activities of district or area management and its implications for their work.

The next feature of DMC/AMC and LMC activity is the question of the resolution of conflict which is important in comparing the styles of a

multi-specialty, 'co-ordinating' committee and a single specialty 'professional' committee. It was noted above that DMC/AMCs face a certain pressure to arrive at consensus decisions because of the multi-specialty membership which is not the case for the LMC although considerations of specialty loyalty or solidarity may be invoked to provide a motive for achieving consensus by the LMC.

Table 7.16 shows very similar patterns of conflict resolution between both committees with the exception that the LMC secretaries placed a relatively high importance on the chairman steering the committee around an issue while the DMC/AMCs' responses emphasised the importance of the specialist decision category. It can be argued that there are no specialists in the LMC membership although some LMCs have a range of advisers who are not GPs. Table 7.17 shows that a few secretaries of DMC/AMCs and LMCs did not accept that conflict resolution was one of the activities which occurred at the committee but the majority of respondents in both categories identified more than one method which their committee used.

The most frequently selected method in both categories of committee was the compromise decision which most closely characterised three quarters of DMC/AMCs and LMCs (see Table 7.18). Only one DMC/AMC secretary chose the avoidance strategy as most characteristic of his committee and no LMC secretary identified this option. Thus DMC/AMCs and LMCs saw the compromise as the most appropriate way of dealing with conflicts of interest in the policy-making process. Significantly, a minority of respondents in each category of committee recognised that the committee adopted strategies of dealing with conflicts which resulted in no decision being made, at least in the short term. 'Agreeing to Differ' or deferring an issue are means by which conflicts are defused if not necessarily resolved in a satisfactory manner. Bearing in mind the degree of specialisation and the significance of intra-professional groups within the NHS it would be

surprising if the DMC/AMC did not face issues where the views of its members differed. Two important examples include the question of medical and other manpower within the local health service and the choice between competing demands for medical equipment within the district or area. In both areas the scarcity of resources and the extent of demand are such that the DMC/AMC needs to regulate demands if the distribution of resources is not to be imposed by the management team or the authority. In such cases strategies which involve unacceptable delay may lessen the influence of the profession over the circumstances or content of their work.

The final variable to be examined in this section is the output of policy from the DMC/AMC and the LMC. The question of formal minutes is examined since these form the objective record of the committees' activity and their distribution implies a form of expectation and continuing relationship with the target committee, authority or team. Table 7.19 shows that 81% of DMC/AMCs sent their minutes to the appropriate management team. In contrast only 39% of LMCs sent their minutes to the FPC. The first finding is as expected but the second demands some form of exploration. It would appear that the LMC frequently relates with the FPC through the LMC secretary who is a 'professional' secretary. The distinction is based upon the fact that most secretaries of LMCs are GPs while DMC/AMC secretaries are usually administrators. It would appear that the authority 'delegated' to the LMC secretary is more extensive than that which a DMC/AMC secretary is usually given.

A minority of LMCs sent their minutes to the management team (16%) or health authority (17%) and this development of formal links would tend to support the view that a few LMCs place increasing importance in the question of local health service management. The close link between a minority of LMCs and the DMC/AMCs is reflected in the fact that a minority

of LMCs sent minutes to the DMC/AMC and similarly 30% of DMC/AMCs sent minutes to the LMC.

Returning to the question of whether the DMC/AMC and the LMC act as constituency bodies it is important to ask from which perspective the question is posed and what is the constituency in question. Undoubtedly the GP survey revealed that most GPs identified the LMC as the most important forum and it is the only distinctively GP committee covering the whole of England and Wales. The formal links with the management team and health authorities were weak but the LMCs did relate closely in many districts to the DMC/AMC. The latter committee was designed as the co-ordinating body for the constituency of doctors working within the district or area. While the DMC/AMC had close formal links with the management team and health authority it did not represent a natural constituency since the interests of its constituent groups were focussed upon general practice, hospital practice or community health. These major divisions in the delivery of care structured the interests of DMC/AMC members and therefore the DMC/AMC is involved in co-ordinating the views represented by other constituency bodies whether they be the LMC, the Medical Staff Committee or the Community Doctors Committee. It should be noted that GPs in some districts had a particular interest in the role of the DMC/AMC since it was the only means they had of attempting to influence management proposals. The hospital doctors and community health doctors frequently had other sources of access to management through Hospital Medical Executive Committees or the Community Medicine Hierarchy.

While the LMC appears to represent the only GP constituency body it should be noted that many GPs took little or no interest in NHS Management and were happy to allow the LMC to act on their behalf particularly since they contributed financially to its funds.

Table 7.1: Date respondent became secretary of the Local Medical Committee

(percentages in brackets)

Year	Multi-District Area LMC		Single-District Area LMC		Total	
Pre 1960	3	(6.1)	2	(5.9)	5	(6.0)
1961-1970	6	(12.2)	3	(8.8)	9	(10.8)
1971			1	(2.9)	1	(1.2)
1972			1	(2.9)	1	(1.2)
1973	2	(4.1)	5	(14.7)	7	(8.4)
1974	8	(16.3)	7	(20.6)	15	(18.1)
1975			1	(2.9)	1	(1.2)
1976	3	(6.1)	2	(5.9)	5	(6.0)
1977	11	(22.4)	1	(2.9)	12	(14.5)
1978	3	(6.1)	2	(5.9)	5	(6.0)
1979	8	(16.3)	4	(11.8)	12	(14.5)
1980	3	(6.1)	2	(5.9)	5	(6.0)
1981	2	(4.1)	3	(8.8)	5	(6.0)
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Area question 2 and Single-District Area question 2.

Table 7.2: Number of hours worked per week as local medical committee secretary

(percentages in brackets)

Hours per week	Multi-District Area LMC		Single-District Area LMC		Total	
< 5 hours	14	(28.6)	21	(61.8)	35	(42.2)
6-10 hours	12	(24.5)	7	(20.6)	19	(22.9)
11-15 hours	5	(10.2)	1	(2.9)	6	(7.2)
16-20 hours	2	(4.1)	-		2	(2.4)
21 + hours	2	(4.1)	1	(2.9)	3	(3.6)
Full-time	14	(28.6)	4	(11.8)	18	(21.7)[1]
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 4 and Single District Areas question 4.

1. Eleven of the LMCs in London were served by a secretariat which included three medically qualified secretaries and their support staff. Thus 'full-time' LMC secretaries almost inevitably served more than one LMC.

Table 7.3: Occupational status of local medical committee secretaries

(percentages in brackets)

Occupation of LMC Secretary	Multi-District Area LMC		Single-District Area LMC		Total	
Practising GP	22	(44.9)	24	(70.5)	46	(55.4)
Retired GP	1	(2.0)	-		1	(1.2)
FPC Administrator	6	(12.2)	1	(2.9)	7	(8.4)
Retired FPC Administrator	5	(10.2)	1	(2.9)	6	(7.2)
Solicitor/Chartered Accountant or Chartered Secretary	3	(6.1)	1	(2.9)	4	(4.8)
Retired NHS Administrator	1	(2.0)	1	(2.9)	2	(2.4)
Retired DHSS RMO	1	(2.0)	2	(5.9)	3	(3.6)
Full-time Medical Secretary	10	(20.4)	1	(2.9)	11	(13.2)[1]
Occupational Health Doctor	-		1	(2.9)	1	(1.2)
Miscellaneous	-		2	(5.9)	2	(2.4)
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 1 and Single-District Areas question 1.

1. This category consists of the London secretariat.

Table 7.4: Frequency of local medical committee meetings

(percentages in brackets)

	Multi-District Area LMC		Single-District Area LMC		Total	
Monthly	30	(61.2)	20	(58.8)	50	(60.2)
Two Monthly	13	(26.5)	9	(26.5)	22	(26.5)
Six Weekly	4	(8.2)	1	(2.9)	5	(6.0)
Three Monthly	2	(4.1)	2	(5.9)	4	(4.8)
Ad hoc	-		2	(5.9)	2	(2.4)
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 7 and Single-District Areas question 7.

Table 7.5: Person responsible for compiling local medical committee agenda

(percentages in brackets)

	Multi-District Area LMC		Single-District Area LMC		Total	
Chairman and Secretary	23	(46.9)	16	(47.1)	39	(47.0)
Secretary	14	(28.6)	17	(50.0)	31	(37.3)
Other	1	(2.0)	-		1	(1.2)
Secretary and Staff	11	(22.4)	1	(2.9)	12	(14.5)
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 8 and Single-District Areas question 8.

Table 7.6: Frequency with which chairman, secretary and members constitute items to the local medical committee agenda

(percentages in brackets)

	LMC Chairman		LMC Secretary		Members	
No Answer	1	(1.2)	-		-	
Frequently	35	(42.2)	68	(81.9)	16	(19.3)
Sometimes	41	(49.4)	14	(16.9)	61	(73.5)
Seldom	6	(7.2)	1	(1.2)	6	(7.2)
Never	-		-		-	
	83	(100)	83	(100)	83	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 9 and Single-District Areas question 9.

Table 7.7: Committees from which the local medical committee receives minutes

(percentages in brackets)

Committee	Multi-District Area LMC		Single-District Area LMC		Total	
Family Practitioner Committee	20	(40.8)	16	(47.1)	36	(43.4)
Area Health Authority	13	(26.5)	13	(38.2)	26	(31.3)
Area Team of Officers, AMT	-		10	(29.4)	10	(12.0)
Area Medical Committee	21	(42.9)	17	(50.0)	38	(45.8)
District Management Teams	13	(26.5)	-		13	(15.7)
District Medical Committee	25	(51.0)	-		25	(30.1)
Medical Executive Committee or Medical Staff Committee	-		10	(29.4)	10	(12.0)
Community Health Council	2	(4.1)	4	(11.8)	6	(7.2)

Local Medical Committee Secretary Multi-District Areas question 10 and Single-District Areas question 10.

Table 7.8: Number of methods used by the local medical committee for resolving conflict

(percentages in brackets)

Number of Methods	Multi-District Area LMC		Single-District Area LMC		Total	
None	2	(4.1)	2	(5.9)	4	(4.8)
1	19	(38.8)	9	(26.5)	28	(33.7)
2	20	(40.8)	15	(44.1)	35	(42.2)
3	5	(10.2)	6	(17.6)	11	(13.3)
4	3	(6.1)	2	(5.9)	5	(6.0)
	49	(100)	34	(100)	83	(100)

Local Medical Committee Secretary Multi-District Areas question 12 and Single-District Areas question 12.

Table 7.9: Methods used by the local medical committee for dealing with conflict

(percentages in brackets)

	Multi-District Area LMC		Single District Area LMC		Total	
Steer Around	16	(32.7)	5	(14.7)	21	(25.3)
Avoid Issue	-		1	(2.9)	1	(1.2)
Find Compromise	44	(89.8)	27	(79.4)	71	(85.5)
Agree to Differ	16	(32.7)	15	(44.1)	31	(37.3)
Defer Issue	5	(10.2)	6	(17.6)	11	(13.3)
Abide by Specialist Decision	6	(12.2)	11	(32.4)	17	(20.5)
	49		34		83	

Local Medical Committee Secretary Multi-District Areas question 12 and Single-District Areas question 12.

Table 7.10: Method of resolving conflict most characteristic of local medical committee

(percentages in brackets)

Method	Multi-District Area LMC		Single-District Area LMC		Total	
No Answer	2	(4.1)	2	(5.9)	4	(4.8)
Steer Around	4	(8.2)	1	(2.9)	5	(6.0)
Avoid Issue	-		-		-	
Find Compromise	39	(79.6)	25	(73.5)	64	(77.1)
Agree to Differ	4	(8.2)	4	(11.8)	8	(9.6)
Defer Issue	-		2	(5.9)	2	(2.4)
Abide by Specialist Decision	-		-		-	
	49	(100)	34	(100)	83	(100)

Percentages calculated downwards.

Local Medical Committee Secretary Multi-District Areas question 13 and Single-District Areas question 13.

Table 7.11: Distribution of local medical committee minutes to other committees

(percentages in brackets)

	Multi-District Area LMC		Single-District Area LMC		Total	
Family Practitioner Committee	26	(53.1)	6	(17.6)	32	(38.6)
Area Health Authority	12	(24.5)	2	(5.9)	14	(16.9)
Area Team Officers, AMT	8	(16.3)	3	(8.8)	11	(13.3)
Area Medical Committee	5	(10.2)	6	(7.6)	11	(13.3)
District Management Team	10	(20.4)	-		10	(12.0)
District Medical Committee	14	(28.6)	-		14	(16.9)
Medical Executive Committee/ or Medical Staff Committee	2	(4.1)	7	(20.6)	9	(10.8)
	49		34		83	

Local Medical Committee Secretary Multi-District Areas question 15 and Single-District Areas question 15.

Table 7.12: The sub-committee structure of local medical committees in multi-district areas

(percentages in brackets)

LMCs with coterminous sub-committees	17	(34.7)
LMCs with 'other' geographical sub-cimmittees	3	(6.1)
LMCs with some coterminous sub-committees	1	(2.0)
LMCs with no geographical sub-committees	28	(57.1)
Total LMCs in Multi-District Areas	49	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Areas question 16.

Table 7.12A: Form of report received by local medical committee from district sub-committees
(percentages in brackets)

Form of Reports	LMC response	
Written report	12	(24)
Spoken report	6	(12)
No report	3	(6)
No district sub-committees	28	(57)
Total	49	(100)

Percentages calculated downwards

Local Medical Committee Secretary Multi-District Area question 20.

Table 7.13: The lay or medical status of secretaries of district medical committee and local medical committee

(percentages in brackets)

	DMC/AMC		LMC	
Lay Secretary	56	(70.0)	21	(25.3)
Medically Qualified Secretary	21	(26.25)	62	(74.7)
Committee Abolished	3	(3.75)	-	
	80	(100)	83	(100)

Percentages calculated downwards.

District Medical Committee question 1,
Local Medical Committee question 1.

Table 7.14: Frequency with which chairman and members of DMC/AMC and LMC submit items for the agenda

(percentages in brackets)

	Chairman				Members			
	DMC/AMC		LMC		DMC/AMC		LMC	
Frequently	40	(50.0)	35	(42.2)	9	(11.25)	16	(19.3)
Sometimes	27	(33.75)	41	(49.4)	28	(35.0)	61	(73.5)
Seldom	11	(13.75)	6	(7.2)	33	(41.25)	6	(7.2)
Never	2	(2.5)	-		9	(11.25)	-	
Not Applicable	-		-		1	(1.25)	-	
Total	80	(100)	83	(100)	80	(100)	83	(100)

Percentages calculated downwards

District Medical Committee question 12, Local Medical Committee Multi-District Area question 9, Single-District area question 9.

Table 7.15: Committees whose minutes are included in agendas for DMC/AMC and for LMC

(percentages in brackets)

	DMC/AMC		LMC	
District/Area Medical Committee			42	(50.6)
Local Medical Committee	24	(30.0)		
Family Practitioner Committee	4	(5.0)	36	(43.4)
Cogwheel System or Medical Executive Committee	15	(18.75)	10	(12.0)
District or Area Management Team	36	(45.0)	23	(27.7)
Community Health Council	2	(2.5)	6	(7.2)

District Medical Committee question 13, Local Medical Committee Multi-District question 10, Single-District question 10.

Table 7.16: Methods of resolving conflicts used by DMC/AMC and LMCs

(percentages in brackets)

	DMC/AMC		LMC	
Steer Around	9	(11.25)	21	(25.3)
Avoid Issue	2	(2.5)	1	(1.2)
Find Compromise	66	(82.5)	71	(85.5)
Agree to Differ	30	(37.5)	31	(37.3)
Defer Issue	13	(16.25)	11	(13.3)
Abide by Specialist Decision	28	(35.0)	17	(20.5)

District Medical Committee question 15, Local Medical Committee Milti-District question 12, Single-District question 12.

Table 7.17: Number of methods of resolving conflicts used by DMC/AMC and LMCs

(percentages in brackets)

Number of Methods	DMC/AMC		LMC	
0	5	(6.25)	4	(4.8)
1	26	(32.5)	28	(33.7)
2	29	(36.25)	35	(42.2)
3	17	(21.25)	11	(13.3)
4	3	(3.75)	5	(6.0)
	80	(100)	83	(100)

District Medical Committee question 15, Local Medical Committee Multi-District question 12, Single-District question 12.

Table 7.18: Method of resolving conflict most characteristic of DMC/AMC and LMC

(percentages in brackets)

	DMC/AMC		LMC	
No Answer	2	(2.5)	4	(4.8)
Steer Around	4	(5.0)	5	(6.0)
Avoid Issue	1	(1.25)	-	
Find Compromise	60	(75.0)	64	(77.1)
Agree to Differ	3	(3.75)	8	(9.6)
Defer Issue	3	(3.75)	2	(2.4)
Abide by Specialist Decision	4	(5.0)	-	
Multiple Strategies	3	(3.75)	-	

District Medical Committee question 16, Local Medical Committee Multi-District question 13, Single-District question 13.

Table 7.19: Committees to which DMC/AMC and LMC minutes are distributed (percentages in brackets)

	DMC/AMC	LMC
District/Area Medical Committee	n.a.	20 (24.1)
Local Medical Committee	24 (30.0)	n.a.
Family Practitioner Committee	9 (11.2)	32 (38.6)
Cogwheel System or Medical Executive Committee	29 (36.2)	9 (10.8)
District/Area Management Team	65 (81.2)	13 (15.7)
Community Health Council	7 (8.75)	-
Area Health Authority	20 (25.0)	14 (16.9)

District Medical Committee question 18, Local Medical Committee Multi-District question 15, Single-District question 15.

CHAPTER 8

THE GENERAL PRACTITIONER AS A CONSTITUENT

8.1 Introduction

From the evidence presented in the previous chapter it seems accurate to conceptualise the GP as a constituent who elects a member to the LMC to represent the doctors in his constituency. This is not necessarily the case with respect to the system through which a GP is selected as a full member of the management team. Within the NHS the GP is an important 'gate-keeper' since it is estimated that he deals with 90% of patient episodes in the practice and is responsible for making referrals to the wide range of other specialists and services provided within the district and indeed the NHS. Although the GP is able to prescribe drugs independent of the district or area budget, his behaviour is of great interest to the DMT/AMT since he can make significant demands upon the services which they provide.[1]

The essence of a health authority or management team's role is to match the available resources to needs within the district or area. Therefore the co-ordination of services, or demands for resources from different branches of the service, requires that each branch should be co-operative to some extent and that mechanisms should exist to foster such co-operation. GPs are not restricted from referring patients for treatment to specialists in other health authorities and so the relationship between GPs and particular health authorities is further complicated. The corollary of this point is that health districts cannot be regarded as self-sufficient entities and therefore some services will be provided by other authorities and not available in the district.

The chapter examines the idea of the GP as a constituent by looking at the significance of the relationship between the practising GP and the GP team member. Following on the examination of the constituent analogy the chapter examines the idea of GPs as a reference group.[2]

8.2 The Selection of a Representative

The Grey Book suggested that the clinical members of the management team should be selected by the medical advisory committee to represent GPs and hospital doctors respectively (Grey Book, para. 4.7). Each member of the District/Area Medical Committee (DMC/AMC) was to represent a group of doctors with common interests. Such interests might be conceptualised in specialty terms for hospital doctors but the most appropriate form for GPs would be geographical groupings in most cases.

According to the Grey Book the population of GPs in a district do not directly select the GP team member although a degree of consultation is indicated. Accordingly the survey of practising GPs asked whether they had the opportunity to take part in the selection of GP members of the DMC/AMC. Table 8.1 shows that 27% of the respondents claimed they had an opportunity to take part in the selection process, 6% did not know, and 66% reported that they had no opportunity to take part. It is not intended to argue that GPs are excluded from such decisions but rather that GPs do not take part and their knowledge about the representative system is deficient. Two respondents pointed to this problem very clearly. The first mentioned that GP members of the DMC/AMC were selected 'by persuading someone in my practice or neighbouring practices to take on the job' (GP 3157). The second commented,

> We have a representative and as there are nine doctors in the town we ask for a volunteer who can give up the time and the evening.
>
> (GP 3180).

Thus DMC/AMC membership is regarded as an unwelcome but necessary duty which places demands upon the time of GPs and therefore selection of members involved finding a willing volunteer, not selecting from candidates. Of the 36 GPs who claimed that they had the opportunity to take part in the selection of DMC/AMC members, two did not know how selection took place or

did not answer the question. Thirteen GPs mentioned that an election was held, six had the opportunity to nominate members, and seven mentioned that the LMC took on the job of selecting DMC/AMC members. Thus only 10% of sample of practising GPs took part in the selection of DMC members although a further 5% mentioned the opportunity to nominate members (Table 8.2). This fits in with the pattern of involvement in professional and advisory committees outlined above in which only 29% of GPs had ever belonged to any of the main committees (see Table 5.3).

The lack of knowledge among GPs about the advisory and management machinery was emphasised by respondent GP 3068,

> As a somewhat isolated rural GP, concerned with the care of patients I know little, or nothing, about District/ Area management.

Similar reasons were given by 8 non-respondents for their failure to participate in the survey. It may be fair to argue that the respondents are those who have more than a minimal knowledge of the subject in question since they were able to complete the questionnaires in most cases. The consequences of a low level of participation in the selection of DMC/AMC members may be less important than the low level of knowledge of GP participation in district/area management since it may prevent the majority of GPs from exercising any influence on the services in the district or area. It may also indicate that practising GPs perceive little impact from GP involvement in local management. The finding that GPs take little part in the selection of members of advisory committees may have little effect on the representative component of the role but a correspondingly more important impact on the executive components. Thus DMC/AMC members may be regarded by the management team or health authority as a source of advice while their fellow GPs doubt their right to use persuasive authority in the implementation of agreed policies.

While it is clear that few GPs take part in the selection of members of the DMC or AMC, the explanation for this low level of participation is not clear. In the next section it is argued that the level of activity in this sphere amongst GPs is restrained by an intervening factor which is termed visibility.

8.3 The Impact of Poor Visibility

It was suggested above that the ordinary GP's activity as constituent is constrained by the degree of visibility of the representative-management system which he has.[3] Poor visibility hinders the extent to which role-sending, in all but the most general sense, takes place since GPs are unaware of the policy-making agenda and therefore unable to send appropriate and timely expectations. Thus the GP who reported that he did not know the name of the GP team member and had not heard of a District Management Team was unlikely either to influence the creation of policies or to be able to support existing policies.

Several factors need to be accounted for in assessing the extent to which the GP may take the role of an active constituent. The first is the level of participation and non-participation in NHS committees. Two sorts of benefits emerge from participation: the GP is able to obtain the knowledge of the structures and processes of the local policy-making machinery, and also the GP is likely to be aware of current issues on the policy-making agenda and the positions being taken by his colleagues and other interested groups. The evidence presented in chapter 5 showed that 71% of GPs had never belonged to any of the NHS or professional committees mentioned in the question (Table 5.3). Furthermore only 14% currently belonged to any of the NHS or professional committees. It therefore follows that only a minority of GPs gain familiarity with NHS policy-making through personal participation.

Another means by which GPs may receive information to enable them to participate in the planning and management of local services is through the distribution of minutes and reports of DMC/AMC and DMT/AMT meetings. The sample of ordinary GPs were asked if they received such minutes and reports and the results are set out in Table 8.3. A third of GPs received reports from the DMC/AMC and only a fifth received reports from the DMT/AMT. Consequently the majority of GPs do not receive such reports and the discrepancy is probably due to the relative frequency with which management teams met in comparison with DMCs or AMCs (Tables 5.23, 5.24). In a large district with perhaps 200 GPs, it would require significant resources to provide each with minutes of each meeting. Additionally some management teams felt that their minutes were confidential and one did not produce formal minutes. Thus the question remains to be answered as to how ordinary GPs are informed of the activities of the DMC/AMC and the management team. The answer which fits the evidence most clearly is that most GPs do not routinely find out about the issues of local management and planning in a formal manner unless those issues are very significant in which case GPs may be specially informed and may attempt to influence policy. Clearly ordinary GPs are largely dependent upon the 'grapevine' for information in the majority of districts concerning the majority of developments.

The extent to which the GP team member may act to increase visibility for the GPs in his 'constituency' is discussed in detail in chapter 11 since there are a number of reasons why he may want to increase or decrease the flow of information to his colleagues. Table 8.4 shows the frequency with which GP team members claimed to produce accounts of their activity as team member of the GPs within their district. Fifty-five per cent of GP team members replied that they never produced accounts for their fellow GPs and the corresponding figure in single-district areas was 71%. This finding

for GP members of AMTs may be explained to some extent by the coterminous relationship with the Local Medical Committee. Thirty per cent of GP members of management teams produced reports for their fellow GPs at least 'sometimes' and such reports may both serve to increase visibility and function to enable a limited amount of accountability of team member to practising GPs and thus act as a base of legitimacy for the team member. It is not argued that such forms of accountability produce a strong basis for legitimating the activity of the GP team member but that in an absence of such underpinnings these reports may play some role.

Recognising the problem of visibility as an intervening variable enables the examination of the relationship between the GP team members and other GPs within a district to be examined in a more realistic light.

8.4 The GP's Expectation of his Representative

To examine the generalised role-expectations which GPs held of the GP team members a typology was adopted from the work of the Brunel Health Services Organisation Research Unit. This suggested three possible types of professional representative: the elected (or negotiating) representative who speaks with the full authority of his colleagues; the representative who speaks for his colleagues but is not able to commit them to any course of action (the non-negotiating representative); and the representative who is simply a member of the team as well as a member of the profession (the type-representative). This formalised typology has as its central concept, the degree of authority which the GPs give to their representative. Thus the 'elected representative' can make decisions on their behalf, the 'non-negotiating representative' can only speak on their behalf and must refer back before making any decisions of consequence, and the 'type-representative' has no authority to speak on behalf of his fellow GPs at all but may only speak as a GP. The final category of representation corresponds most closely with the idea of microcosmic representation referred to above.[4]

There are undoubtedly problems in applying such a distinction to discover the views of GPs and others concerning the role of the GP team member. It was important that the respondents recognised that the question concerned the role of the GP team member not the performance of the GP member in their district. It had been demonstrated that the level of GPs' knowledge was low and that the extent of visibility was also low and so each representative category was described in a single sentence and respondents were asked to choose between them.

Table 8.5 shows the choices made by the sample of practising GPs. Firstly, 12% stated that they were unable to make a choice between the options because of their lack of knowledge. Forty-two per cent of GPs favoured the option of the non-negotiating representative, 25% selected the negotiating and 20% chose the type-representative. The first finding is therefore that there was a wide range of opinion among GPs and also a significant aspect of uncertainty or ignorance. It might be argued that the non-negotiating representative provided an option which implied a middle-way between two 'extreme' positions. It also tended to reflect most closely the wording of the Grey Book which referred to the GP team member as one of the DMC representatives. It is not therefore surprising that the largest proportion of respondents chose this option. One respondent did elaborate on this view in the following way,

> An elected member of the DMC who is bound to the decisions of the DMC and delegated to put those decisions for consideration and hopefully obtain consensus.
>
> (GP 3190)

Clearly the view described falls into the category of a delegate whose authority is circumscribed and he is 'bound' to the views of those he represents.[5] It is assumed that the GP member is able to obtain clear 'decisions' for the DMC to inform his actions as a member of the corporate executive. A less rigid interpretation of this view was put forward by GP 3185 who argued,

> He is not a delegate bound by decisions of LMC or DMC but should represent broadly their views.

This interpretation is closest to that of the non-negotiating category since the respondent does not insist on the role of a delegate but argues that the GP team member should 'represent broadly their views'. This view also takes a realistic view of the potential of the DMC in the light of the findings of this study presented in chapter 6.

Another respondent chose a strong form of negotiating representative with the following qualification,

> A decision-maker is required. Not a multiplication of advisors and opinions.
>
> (GP 3014).

This view does not mention representative aspects of the role but emphasises the component of decision-making implied in the idea of a manager. There is implied criticism of the advisory or representative system with the suggestion that duplication or multiplication is a consequence of such systems.[6] In contrast to that view is the response of GP 3140 who supported the type-representative category,

> 'I' am not represented as the member is not elected by me and sends me no reports. I have no doubt that he represents general practice fairly well but not any individual GP but himself.

The respondent links representation with election and accountability in such a way that these two factors are seen to underlie legitimate, representative authority. In consequence, while accepting that the team member performs in a satisfactory manner he represents no-one but himself. He is therefore a GP voice and not a representative of others. This view implies no relationship between the GP team member and other GPs in the district beyond the fact that the GP team member practices within the district and speaks as a GP.

8.5 The GP and Constituent Activity

The extent of interaction between the GP team member and practising GPs was examined as an indication of the relationship between a potential role-sender and the target of expectations. From the GP questionnaire 29% of GPs reported that they had contacted the GP team member and 26% reported that they had been contacted by him (Table 8.6). Only 29% of GPs claimed they had personally contacted the GP team member but this does not necessarily mean that the constituent-representative model breaks down. This pattern of initiation of contacts or role-sending takes place within the structural conditions of general practice in which GPs work in practices and would frequently share an interest in which case one of the partnership might act as a role-sender on behalf of his partners. It is clear that 70% had not contacted their representative personally in the preceding five years suggesting that many GPs were not in the habit of sending particular expectations to the GP team member although they may share generalised expectations of the role.

The first explanation for low levels of contacts with GP team members being initiated by GPs is that many ordinary GPs see very little to be gained through the local management system. The reasons for this include widespread ignorance of the structure and processes of management, poor visibility of current policy-making, and an alternative means of pursuing interests through the Local Medical Committee. Perhaps the most obvious explanation is that many GPs were satisfied with the performance of the GP team member. A few respondents made clear that their comments concerned the structural aspects of representation and management, not the performance of an individual team member. The view that GPs were satisfied with the performance of their team member lends support to the view that GPs within a district have shared interests resulting from their practice orientation

and common speialty which enable one of their number to represent homogenous interests which he shares because of his occupational basis.

Before examining the details of GPs' interactions with the GP team member they were asked simple questions about their attitudes towards advisory committees and management teams within the area or district. It was hypothesised that to the extent that GPs took an indifferent or hostile attitude towards those committees they were likely to take little part in them while a positive attitude might suggest various forms of action by the constituent. The sample of GPs was asked to identify the most important forum for representing the views of themselves and their colleagues. Table 8.7 shows that 58% chose the Local Medical Committee and a further 8% selected the Family Practitioner Committee. Almost a quarter chose more than one committee which involved combinations of the management team, DMC/AMC and the Local Medical Committee. This multiple choice underlines the point that these committees exist for and fulfil different objectives and that choosing one was a difficult task. It appears that 58% were willing to choose the Local Medical Committee although it did not directly relate to the management team at district level.

Two further questions concerned the GPs' perception of the potential of the management team to produce significant changes in the pattern of health care expenditure within the district and also whether the respondents felt such changes were necessary. Table 8.8 shows that 50% of practising GPs thought that significant changes were needed in the district with the corresponding finding that 43% felt that significant changes were not needed. The following question produced an identical proportion of respondents (50%) who felt that the management team were capable of producing such changes within the district. A further 35% felt that the management team was not capable of producing significant changes in the pattern of health care spending locally (see Table 8.9). Since more than a third of the respondents implied that the management team is in the business of making

marginal adjustments rather than important changes it might be expected that a significant proportion of GPs would not be concerned with sending particular expectations to the GP team member.

The questionnaire returned to an indicator of behaviour since questions of attitude are difficult to interpret and do not necessarily provide good explanations of behaviour. In chapter 5 it was shown that formal participation by GPs in NHS professional and advisory committees is low and that a small proportion of GPs are frequently active in more than one committee. The GP sample were asked whether they had ever contributed an item for the DMC or AMC agenda since this was envisaged as the main means by which the medical view would be formulated and passed to the management team. Table 8.10 shows that only 14% of the respondents had ever contributed an item to the DMC/AMC agenda. This fits closely with the finding from Table 4.2 that only 12% of respondents were either currently or had previously been members of the DMC/AMC.

It was noted above that 29% of the GP sample claimed to have contacted their GP team member personally and this figure is almost exactly twice that of those who had raised an item with the DMC/AMC.[7] Those who had contacted their GP team member were asked to give the reason in an open question. In four cases the GP team member was a partner of the respondent and therefore discussions of local issues were facilitated by the structure of work. This does raise the point that GP team members who work in partnerships may be open to the influence and views of their colleagues and therefore able to discover the views of their colleagues even if consulting the constituency is a more difficult process. These four respondents mentioned discussing issues ranging from the local casualty services to the Regional Strategic Plan. Eight respondents mentioned that they had contacted the GP team member in response to threats to services including the community midwifery

services, the geriatric services and the psychiatric services. Three respondents mentioned GP hospital posts and a further four reported contacting their GP team member about GP beds in cottage or District General Hospitals. Finally two GPs mentioned the question of attached staff to their practices and two had made suggestions for improvements to services. The last two reported disillusionment with the response to their suggestions.

It is notable that only two GPs reported having made suggestions for improvements to services in the district or area and their disillusionment suggests either that the suggestions were not timely and appropriate or that the team member was unable or unwilling to follow them. The other respondents appeared either to have responded to proposed changes or threats or to have contacted the GP team member in relation to practice arrangements such as the question of access to hospital beds or the question of attached para-medical staff.

The pilot survey indicated that the majority of GPs were unlikely ever to have contacted their GP team member and so the questionnaire included a hypothetical question to discover how many GPs could understand the purpose of the GP team member. The question was posed, Can you give an example of a matter about which you might approach the GP member of the District Management Team? The question was addressed to those GPs who had not contacted their representative personally and was answered by 101 GPs. Seventy eight GPs could not think of any reason for contacting their representative and 23 gave a series of reasons why they might contact him which were similar to those GPs who reported contacts with the GP team member. As a proportion of the total number of respondents to the GP survey around three-fifths of GPs could not think of any reason why they might contact the GP team member.

In the case of GPs in single-district areas this ignorance may be less significant to the extent that the LMC acts as a constituency body on their behalf. In health districts it places an important responsibility on the GP team member since the constituents are largely passive and show a low level of knowledge about the management system.

8.6 The GP as a Source of Information and Advice

Since the majority of GPs never contact their team member to express their views or send particular expectations the sample of GPs were asked whether they had ever been contacted by the GP team member and what the purpose of that contact was.[8] It was assumed widely that the GP team member would undertake various activities to ensure that the line which he pursued was in keeping with the views of his fellow GPs (DHSS, 1970, paras.4.9-4.12). To argue that GPs act as a cohesive occupational sub-group with clearly articulated interests is not consistent, at least in relation to the concerns of local management, with the findings of ignorance and poor visibility commented on above. However GPs may act as a 'reference group' or a source of information for their team member and it needs to be stressed that GP partnerships may constitute important groups of GPs whose views can be obtained through consultation.

The GP sample were therefore asked whether they had been contacted by their representative and what was the purpose of the contact. The purpose of the contact was obtained using four main precoded options which were designed to be sufficiently broad to prevent the researcher making unreasonable assumptions from the data. The four categories suggested were: to obtain the respondents' views on district priorities; to obtain general advice; to seek advice because of a respondent's special expertise; and to obtain information on which a respondent had special knowledge. The two

most widely reported purposes were requests for general advice (22) and also requests for information (21) (see Table 8.11)[9]. Fourteen of the respondents said they had been approached regarding questions of priorities and 15 because of a special expertise which they possessed. These responses must be considered against the 97 (73%) of GPs who had never been contacted for any of these purposes. It is clear that the GP team members contacted particular GPs for advice or information and that these were GPs with special expertise or circumstances in the case of specific advice or information. It is likely that other GPs were contacted through social or professional channels and that those contacts were a means by which the GP team member kept in touch with the views of GPs in the district or area.

The evidence presented does not support the concept of the constituency of GPs as a reference group in any but the most general sense. The GPs do not show evidence of close cohesion except in the sense of shared practice orientation and there is little evidence of more than a minority of GPs being contacted for advice or information. Examples of closer cohesion included the partnership and also membership of the LMC discussed in chapter 7. The problem of boundary differences between the LMC and the health district were mentioned above and only become significant when the interests of GPs in different districts can be shown to differ significantly. The findings relating to GP expectations suggest that some GPs have clearly articulated interests in the range of services provided in the district and therefore a segment of interests will differ from those held by GPs in other districts. Additionally they share a wide range of interests by virtue of their relationship to the NHS and their practice orientation. GPs' rights to prescribe with few constraints and also to refer patients across administrative boundaries give them a status within the health district which is markedly different from their consultant colleagues.

Summary

Although the anology of a constituent-representative relationship has been widely assumed in policy statements the evidence does not seem to support this view except in a nominal sense. Participation in the representative selection processes is low and doctors seldom provide a base for representative authority or action. Active participation in professional and administrative committees is a minority activity and many GPs appear willing to leave such tasks to the interested few. The consequence for the principle of corporate management is that the GP team member cannot commit his colleagues to policies, and implementation of policies insofar as GPs are concerned may be problematic.

The problems of ignorance and poor visibility of practising GPs prevent active participation by GPs. The veil may be partially lifted through the constituency bodies of the LMC and the DMC.

Table 8.1 Number of GPs who had the opportunity to take part in the selection of district/area medical committee members
(percentages in brackets)

GP's Response		
Don't know	8	(6.0)
Yes	36	(27.1)
No	88	(66.2)
No Answer	1	(0.75)
Total	133	(100)

Percentages calculated downwards.

GP sample question 5.

Table 8.2 Means of selection of GP members of district/area medical committees reported by the GP sample
(percentages in brackets)

Means of Selection		
Not Applicable	97	(72.9)
Election	13	(9.8)
Nomination	6	(4.5)
Cogwheel Divisions	8	(6.0)
LMC Appointment	7	(5.3)
No Answer	1	(0.75)
Don't Know	1	(0.75)
Total	133	(100)

Percentages calculated downwards.

GP sample question 6.

Table 8.3 Number of GPs who receive minutes or reports from the district/area medical committee and the district/area management team

(percentages in brackets)

Response	Received Reports from DMC/AMC		Received Reports from DMT/AMT	
Yes	44	(33.1)	27	(20.3)
No	86	(64.7)	105	(78.9)
Don't Know	3	(2.2)	1	(0.75)
Total	133	(100)	133	(100)

Percentages calculated downwards.

GP sample question 8.

Table 8.4 Frequency with which GP team members produce accounts of their activities for GPs in the district

(percentages in brackets)

Frequency	GP members of DMTs		GP members of AMTs		Total	
Frequently	9	(12.0)	-		9	(10.1)
Sometimes	14	(18.7)	2	(14.3)	16	(18.0)
Seldom	13	(17.3)	2	(14.3)	15	(16.8)
Never	39	(52.0)	10	(71.4)	49	(55.1)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 36.

Table 8.5 Role description of GP team member chosen by GPs

(percentages in brackets)

Role Description		
Negotiating Representative	34	(25.6)
Non-Negotiating Representative	56	(42.1)
Type Representative	26	(19.5)
No Answer	11	(8.3)
Don't Know	6	(4.5)
Total	133	(100)

Percentages calculated downwards.

GP sample question 25.

Table 8.6: Number of GPs who had contacted or been contacted by the GP team member

(percentages in brackets)

GP Response		
Contacted Team Member	38	(28.6)
Contacted by Team Member	35	(26.3)
	133	

GP sample questions 16 and 19.

Table 8.7 GP's view of the most important forum for representing the interests of themselves and their colleagues
(percentages in backets)

GP Response		
Family Practitioner Committee	11	(8)
Local Medical Committee	77	(57.9)
District/Area Medical Committee	7	(5.3)
District/Area Management Team	1	(0.75)
Other	1	(0.75)
Multiple Choice	31	(23.3)
No Answer	2	(1.5)
Don't Know	3	(2.3)
Total	133	(100)

Table 8.8 GPs' views as to whether significant changes were required in the pattern of expenditure in the district
(percentages in brackets)

GP Response		
Significant changes required	67	(50.3)
Significant changes not required	57	(42.9)
Don't Know	5	(3.8)
No Answer	4	(3.0)
Total	133	(100)

Percentages calculated downwards.

GP sample question 10.

Table 8.9 GP's views as to whether the district/area management team is capable of producing significant changes in the patterns of health care delivery within the district

(percentages in brackets)

GP Response		
Significant change possible	67	(50.3)
Significant change impossible	47	(35.3)
No Answer	9	(6.8)
Don't Know	10	(7.5)

Percentages calculated downwards.

GP sample question 13.

Table 8.10 Number of GPs who had contributed an item for the district/area medical committee agenda.

(percentages in brackets)

GP Response		
Yes	19	(14.3)
No	112	(84.2)
Don't Know	1	(0.75)
No Answer	1	(0.75)
Total	133	(100)

Percentages calculated downwards.

GP sample question 7.

Table 8.11 GP's explanations of reasons why GP team member contacted them

(percentages in brackets)

GP Response		
On matter of priorities	14	(10.5)
For general advice	22	(16.5)
For specific expertise	15	(11.3)
For information	21	(15.8)
Total	36	

Percentages refer to total number of respondents, i.e. 133.
Ninety-seven GPs had never been contacted by the GP team member.

GP sample question 20.

CHAPTER 9

THE GP MEMBER OF THE DISTRICT/AREA MANAGEMENT TEAM

9.1 Introduction

As a member of the management team the GP combines the roles of general practitioner and member of a team who share a corporate responsibility for the operational planning and management of health services. The role is unique in the district and also a comparatively new development within the NHS. In this chapter the personal expectations of DMT/AMT members are examined and the corresponding behaviour of the GP team member. In previous chapters the concern has been purely with the expectations of other GPs; here the concern is with the members of the team who represent different functions. Four of the team members are full-time officers and the remaining two are primarily practising doctors whose team membership is inevitably a subsidiary activity.

9.2 The GP as Team Member

GP and consultant members of the management team share the important characteristic that their involvement is only a subsidiary part of their duties. Table 9.1 shows that GP team members reported spending significant numbers of hours at DMT/AMT meetings or in work directly related to those activities. It has been shown that this commitment meant reducing the amount of time spent in clinical, teaching and research activities by consultant team members (Mason, 1976). Additionally GPs have written in medical journals suggesting that the time commitment is significant and that remuneration should be increased (Jenkins, 1982). In Table 9.2 the number of hours spent per week by GP team members on team activities is categorised and there are no clear differences between members of DMTs and members of AMTs. This may be significant since some GP members of DMTs

have claimed that the time demands have been increased since the creation of District Health Authorities corresponding to the old health districts (Jenkins, 1982). It is argued that attendance at District Health Authority meetings is an extra burden for the GP team member.[1]

The clinical members of the management team have to find as much as one day a week for team activities. This is especially difficult for the GP since this diverts time from practice which either has to be made up at different times or partners have to cover for the absent doctor. Cases were found which made it clear that the partnership may determine how much time a GP can give to management team activity during working hours. For instance, one GP team member said,

> We have found a young doctor who is interested in being the next DMT GP, when I retire at the end of the year. He is a member of the LMC and quite able but his partners object to him joining the team ...

Such objections were not uncommon and it was widely believed in one district that the time spent in DMT activity by a senior partner had contributed to the dissolution of that partnership. Another GP team member explained that the DMT session was done during practice time since it was a paid session but that other committee work, the Local Medical Committee and the Family Practitioner Committee took place on his afternoon off. He took pains to emphasise that he still did his fair share of work within the practice,

> ... I see as many patients as my colleagues, I do as many visits as my colleagues and the rest but I do them at different times. I start my circuit, for instance, at half-past eight in the mornings, they start at nine; ...

The GP team member is not always able to rely on a junior doctor to cover for him in his absence as many consultants might do although some GP team members may have GP trainees who may share the workload. The partnership was frequently referred to in terms of a business and similar consid-

erations were made to those a small business owner might be expected to make.[2] In contrast the full-time officer members of the team are not subject to such constraints.

Inevitably the clinical members of the team must be subject to different expectations than the full-time officers. The GP's relationship with fellow GPs is very different to the Chief Officer's relationship with his staff. The management team are bound together by their collective responsibility to the health authority and the rule of consensus by which they work. The operation of this rule is discussed in more detail in section 10.2. The commitment of the clinical members to the management team is of limited tenure and the effects of this characteristic should not be underestimated. The Grey Book suggested a maximum term of office of five years although in some districts the nominal term of office has been considerably shorter than this (DHSS 1972, para. 4.11). Table 9.3 shows the nominal length of appointment of GP members of DMTs and AMTs. Nine per cent of GP team members were selected for a period of less than two years and 33% for an unspecified period. The remaining 57% were appointed for a period of more than two years. The limited tenure of the post takes on a different complexion if there is a dearth of candidates to take on the role when the position is vacant.

A major element of the commitment of GP team members is to the formal DMT or AMT meeting. Table 9.4 shows that management teams met far more frequently than District or Area Medical Committees and it may be implied that the degree of commitment required is considerably more for the GP team member than for the member of the advisory committee. Table 9.5 shows that 46% of team meetings lasted for about three hours and a further 34% lasted two hours. This finding corresponds closely with that of Mason who found that about three-quarters of the meetings lasted about three hours (Mason, 1976, p.19). In a study conducted in the West Midlands Region

Page found no correlation between the frequency of team meetings and their length (Page, 1981, p.29).

9.3 GP members of Management Teams and the Concept of Marginality

The position of independent contractor services in the NHS is such as to suggest that the GP team member may have marginal interests in the business of the team when compared to the chief officers or the consultant. The degree to which the GP member participates in team business, both formally and informally, may demonstrate a degree of marginality which is due in part to his relative structural isolation and in part to the nature of GP interests (Eskin, 1979). One GP team member stated that much of the DMT business concerned the hospital services and was not of direct interest to GPs. Such an attitude suggested that the GP team member might take the role of a watchdog waiting for items which directly concerned or threatened GPs rather than taking a full part in other business (Royal Commission, 1978, para. 9.7).

One of the variables used to assess the concept of marginality was the frequency with which the GP was perceived by other team members and perceived himself to contact team members between formal meetings. Measuring the extent and nature of these contacts more accurately would require widespread use of diary analysis which may fail to achieve the desired results.[3] Instead the administrator and the GP were asked to assess the frequency with which they contacted and were contacted by other members of the team. The results are shown in Tables 9.6 - 9.12.

Table 9.6 records the response to the administrators' questionnaire concerning the frequency with which administrators claimed to contact the other members of the team. Not surprisingly, the most frequent contacts were with the officer members of the team. For instance, 93% of the administrators claimed to contact the finance officer frequently and 7% did

so sometimes. In comparison only 43% claimed to contact the consultant member frequently and the corresponding figure for the GP was 11%. A further 52% of administrators reported contacting the consultant member sometimes but it is notable that almost a third of the administrators seldom contacted the GP member. Thus the administrator who acts as the co-ordinator of the team contacted the clinical members less frequently than the chief officer members and by this indicator the GP team member appeared least 'popular'.

Table 9.7 and 9.8 look at the findings for District and Area Administrators separately. No District Administrator claimed to contact the GP member frequently although 49% claimed to contact the consultant frequently. In the single district areas 55% of Administrators claimed to contact the GP team member frequently although 45% claimed to contact him seldom. This may indicate that in some single-district areas the GP team member was seen as a more important team member because of his relationship with the Local Medical Committee but this explanation is particularly speculative. In other aspects there was a broad similarity between District and Area Administrators.

Before discussing this finding further it is important to examine the converse findings, namely the extent to which GP members claimed to initiate contact with other members of the team including the District or Area Administrator. Table 9.9 shows that 91% of GPs claimed to contact the administrator frequently or sometimes and similarly 78% contacted the consultant member with similar frequency. The reported contacts with the nursing officer, finance officer and community physician were markedly less frequent. At first sight it appears that the two findings concerning the Administrators initiation of contacts with the GP and the corresponding contacts from the GP are inconsistent. This finding reflects the one-sided

relationship which the GP member has with the administrator who acted as the source of information and was responsible for servicing the management team. The GP members also claimed to contact the administrator more frequently than the consultant member of the team which supports the idea that in some respects the interests of GPs and consultants differ markedly which is the reason underlying separate representation on the management team. Again the structural differences between the practice orientations of consultants and GPs must be born in mind in interpreting these findings since GPs have practice commitments which may prevent them giving priority to DMT business. Additionally they may be located on different sites making communication difficult. The consultant member may frequently work at a large district hospital in which the administrative offices are also based.

Another means of examining the hypothesis of marginality was to ask the Administrators and the GP members how frequently they were contacted by other members of the team. This also provided a means of examining the inconsistencies between the GPs' and Administrators' perceptions. These are relative perceptions since they compare the frequency of contact between different team members and it may be that where the Administrator perceived contacts initiated by the GP as infrequent, the GP would claim to contact the Administrator frequently. Table 9.10 shows the frequency with which GP members claimed they were contacted by other team members. Once more the most important team member in terms of contacts is the Administrator and there is a similar pattern of contacts with the community physician and the consultant. The Finance Officer and the Nursing Officer were perceived to contact the GP team members relatively infrequently in comparison. The GP team member sample contained only 14 single-district areas and so these findings are not significant when taken alone. Table 9.11 shows that the Administrators' perceived that they were contacted relatively

less frequently by the GP members than by other members of the team. As expected contacts from the chief officers were relatively frequent and contacts with the consultant were slightly less frequent but contacts initiated by the GP member appeared relatively infrequent.

These findings suggest that the GP team member is relatively isolated in the network of team membership.[4] He is perceived by the Administrator as initiating contacts relatively infrequently and his contact with the team appears to take place largely through the administrator. The pattern of contacts which administrators reported with the consultant team members lends support to the view that the provision of hospital services constitutes the most significant element of team business while the development of primary care services is not totally within the powers of the team. One community physician commented that the GPs were still relatively isolated from the financial difficulties facing the service in a way that hospital doctors were not. This structural issue is an important factor in the marginal position of the GP in relation to much team business. One GP commented that his role on the team was that of a watchdog 'safeguarding consumer interest' by which he meant the interests of patients to which he felt particularly sensitive as a GP and which, he felt, were not sufficiently represented on the team.

These simple indicators of interaction suggest that the GP team member has a distinctive, one-sided relationship with the Administrator who acts as team co-ordinator if not chairman. The patterns of contact appear less frequent than those with the consultant member although the range of information on this question is limited.[5] The next section examines the actual contribution of the GP team member to the business of the team.

9.4 The GP member's contribution to team business

It was argued in the Grey Book that clinical members of management teams should be full, equal members of the team, sharing in its collective responsibility, not individually accountable to the area team of officers but accountable only to their medical colleagues (DHSS, 1972, paras. 4.9 - 4.12). To assess the GP member's contribution to team business requires knowledge of the way in which such teams operate. In a study of four management teams which analysed the content of 25 team meetings, 671 different items of business were identified (Haywood and Alaszewski, 1980). The authors produced four main categories into which the items were placed; items for information, items regarding the process of decision-making, items concerned with position-taking, and finally substantive decisions. About a fifth of the items identified concerned the process of decision-making and a further ten per cent related to the teams position-taking in relation to other agencies. More than a third of the items were described as matters for information since they were not connected to any decision being made. This left a third of the items which were broadly identified as decisions. These items were sub-divided into routine and non-routine decisions. Routine decisions involved the application of predetermined or previously agreed rules to a particular situation and constituted three out of very four decisions. The important finding was that less than ten per cent of team agenda items concerned substantive decisions.

It follows that the GP member's contribution to team business must be understood in the light that a substantial proportion of time is spent on items of information with no direct relevance to policy decisions and on the making of routine decisions using existing rules. The GP member questionnaire contained questions designed to examine the formal and informal modes of participation by the GP in team meetings. The main area of concern was with the raising of issues in team meetings and the formal aspect of this issue

was indicated in many teams by the presentation of papers by team members. The same question was included in the Administrator questionnaire which enabled a comparison of the range of participation through the presentation of papers although the District or Area Administrator cannot be regarded as typical of the Chief Officer members in this respect. Each respondent to the Administrator survey replied that the team operated, not necessarily exclusively, by discussing papers produced by members. It is not surprising that the most obvious finding was that 98% of administrators reported producing papers frequently or sometimes while the GP members produced papers much less frequently (see Table 9.13). However 35% of GPs did report producing papers sometimes and only 18% reported that they never produced papers. Thus, significant numbers of GPs reported that they produced papers for the management team to discuss and thus operated to some extent in accordance with the normal administrative pattern of operation for an executive team.

Undoubtedly this form of participation causes difficulties for most GPs who are only able to give limited time to the activities of team membership and who have limited secretarial and administrative forces at their disposal. It was found from the District and Area Administrator questionnaire that less than a quarter of GP team members even had the use of offices at the team headquarters. A similar finding was reported by Page in the West Midlands Region (page 30)[6]. It is however important that the GP team member should be able to raise issues or make proposals as an equal member of the management team. To facilitate this it is important that team members recognise the nature of the clinical members' contribution and the constraints under which they operate. One GP team member made this point in the following manner,

> One's either got to be proud of presenting anecdotal evidence, and not afraid to do it, or one's going to be embarrassed. Now, my experience is that, in committee, anecdotal references to

> one case one has dealt with oneself tend to turn everyone else off because they feel that it is too biased to mention in what ought to be a fairly high-level, general, decision-type meeting. There'll be others present who will say "Yes, well, where's your references, where's your paper, who wrote it, which university and when?" Now the GP hasn't got access to that kind of information, he's going to always tend to be anecdotal and he should be proud of it.

The GP went on to argue that GPs should try to produce papers which are well reasoned and backed up with evidence but that the lack of suitable resources made this very difficult. There is a sense in which the GP member needs to cope with the expectations of administrative and scientific means of work which both emphasise the criteria of evidence and of proposals clearly based upon acceptable knowledge about the needs and resources for services or the scientific adequacy of various procedures.

In examining the role of the GP member as an active initiator of items for discussion it is important not to ignore the aspect of reaction to proposals put forward by other team members or from outside the team. The powers of the management team are limited and many proposals or constraints come from outside the team's control. Therefore the clinical members need to respond to proposals effectively as well as initiating their own items of business. For instance the planning system in operation in the NHS immediately prior to the study was complex and required the management team to devise operational plans in the light of strategic plans and priorities from other management levels within the service and therefore the reactive role was perhaps as important as the 'proactive' role especially at the district level which concentrated on operational management.[7]

9.5 Personal Objectives Identified by GP team members

While GP team members are subject to expectations from a variety of sources they also have a series of personal objectives which are not the sum of those expectations to which they are subjected nor can they be

reduced to a response to the powerful expectations although these are important influences. To examine the range of these personal expectations GP team members were asked to identify their personal goals as members of the team. This question was difficult for the respondent as well as for the investigator to interpret since many respondents may have had no clearly articulated objectives which could be simply spelt out. However twelve respondents replied indicating a very general objective which concerned advocating the interests of GPs within the district. An example was GP team member 008,

> ... to improve the image and services provided by GPs and to have these recognised within the District by other disciplines.

It was noted above that GPs have effective mechanisms, notably the Local Medical Committee and the General Medical Services Committee, for pursuing their interests at other levels within the service but in many cases there was little effective machinery within the health district and many GPs perceived that their interests lay at other levels within the NHS.[8] Respondent 073 also indicated a role characterised by the idea of advocacy at the local level,

> To obtain the best conditions for primary care within the constraints operating at the time.

This objective implies that the management team has powers to improve the conditions under which primary care teams operate although it suggests that the ability to improve conditions is of marginal rather than central concern to his colleagues.

Another aspect of GPs' objectives mentioned by eighteen respondents was the significance of community services in relation to the hospital services which take the majority of management team budgets. Respondent 046 stated,

> I try to ensure that the team is not totally 'hospital oriented' and remind them that most care takes place in the community

Thus, within an administrative structure designed to promote integration of the three branches of the NHS the GP member felt that considerations regarding the hospital service were pre-eminent and that part of the role involved fighting for the relatively deprived community sector. Thirteen respondents expressed their advocacy of the community sector in terms of obtaining increased resources for community services and GP member 055 expressed this fairly clearly,

> to obtain an increase in proportional finance allocation to community care.

This finance was most frequently to be spent on community manpower and among the nine respondents who mentioned this area were those who emphasised the relationship between GPs and community staff through references to the primary care team or attached staff to general practices. For instance, respondent 065 spoke of 'the extension of the primary care team', and respondent 071 aimed,

> To provide attached nursing, health visitors and physiotherapists for all GP groups locally.

This is perhaps the area in which the management team is most able to assist the GP in the provision of services to patients in the community although questions of the appropriate means of managing such staff may not always be easily resolved.

An important objective reported by GP team members was the co-ordination of primary and secondary care services. The role was frequently understood as that of the catalyst encouraging the integration of services. The underlying problem seen as preventing such integration was ignorance and misunderstanding amongst hospital doctors of the role of GPs and vice versa. For instance, GP member 001 identified two relevant objectives,

1. To secure much better integration between hospital services and GP and community services.
2. To get better understanding of the roles of GPs by hospital colleaques

Respondent 095 also assumed that better knowledge and understanding would result in improved services to patients,

> Better understanding between hospital and district and between consultants and GPs to provide a better service for the district.

A characteristic of these objectives is that they are phrased in individualistic terms such as the improvement of interpersonal relations or communication between GPs and hospital doctors. This is to be expected since professional ideology promotes the importance of the medical peer group and the referral system emphasises the question of professional responsibility and its transfer, temporarily, to named consultants.

Seven GPs gave specific objectives relating to the position of GPs within the district and the access to technology which was seen by many as a means to enhance that status. For instance respondent 029 reported the following objective,

> To preserve an open diagnostic service for primary care so that it may be more self-sufficient and independent of the consultant outpatient clinics.

Thus the objective of preserving autonomy is present amongst GPs as an intra-professional group as it is also present amongst the medical profession as a whole. Additionally this respondent felt the need to defend his colleagues' 'open access' which he assumed to be threatened.

Finally three GPs commented upon the importance of their role as a member of the team and the significance of pursuing collective interests rather than sectional goals. Such objectives suggested that the GP team member must balance responsibility to the team and its objectives with responsibility to the GPs he represented.

The GP team members identified their personal objectives largely in instrumental or political terms. They assumed a pluralist situation in which

there was a competition for resources, albeit amongst unequal competitors with the giants of secondary care services ranged against the less powerful representatives of primary care and community services. The most important identification was with the needs of independent GPs, not the collective loyalties of the team which is to be expected since the team membership is only a subsidiary activity for the GP members.

9.6 The GP member as a Team Representative

As an equal member of the management team the GP shares in the collective responsibility of the team but is only accountable to his colleagues or the electoral body, the District or Area Medical Committee. The roles of team member and representative of his peers may conflict when the pressures to agree with a team decision opposes the interests or views of his fellow GPs. The pressures to arrive at consensus decisions were partly due to the fact that the health authority had to take responsibility for a decision where the team could not agree. One means of coping was to negotiate with his colleagues and his fellow team members to come to an acceptable, it not optimal, decision.

The first element of this process of negotiation is the activities which the GP team member engages in to find out the views of his fellow GP where these are not clear. The GP team members had certain standard procedures such as consulting the Local Medical Committee, GP Cogwheel Division, or GP Council or Forum. The Grey Book suggested that the main source of medical views would be the District or Area Medical Committee and therefore GP team members were asked how frequently they raised issues at the DMC or AMC (see Table 9.14)[9]. Although 20% of respondents answered that they seldom or never raised issues at this forum, 75% mentioned that they frequently or sometimes raised issues. It appeared that GP members of the District Management were more likely to raise matters at the DMC than were members

of the Area Management Team and this was supported by the findings from the DMC/AMC secretary survey (see Table 9.15). This supports the view that the coterminosity of Local Medical Committees with single-district areas was significant for the representation of GPs' interests. The DMC/AMC secretaries reported that GP team members raised issues more frequently than the GP team members themselves answered (see Tables 9.14 and 9.15). This was because of the relative infrequency of the DMC/AMC meetings in comparison to team meetings and the fact that the team member could not consult the DMC/AMC on any but the most important issues.

Another means by which the GP team member may undertake negotiating activity on behalf of the team is suggested in the Grey Book which argued that clinical members should persuade their colleagues to implement policies decided by the management team (DHSS, 1972, para. 2.55). Such activity has different implications for the GP and consultant team members because of the difference in the terms and the content of work between GPs and consultants. (Of course the community physician could use hierarchical authority because of the organisation of community medicine.) The first difference in the terms of work stems from the 'employed status' of hospital doctors and the independent contractor status of GPs. These imply different practice orientations since the hospital doctor is dependent upon district budgets while the GP's resources are controlled by the Family Practitioner Committee. Since the content of work varies along specialty lines the GP operates with a distinctive style and practices are relatively geographically isolated from each other. In contrast the hospital doctor is dependent for a wide range of resources on obtaining the support of the management team even if the resources are distributed at another level in the NHS. Thus the consultant may be able to persuade his colleagues to support a particular policy through personal contact in the hospital and the range of professional and advisory committees that exist in the hospital.

The GP has not got the same network of links with other GPs who may practice in another town. Additionally the impact of team decisions upon the GP may not appear to be particularly important although his support in implementing policies may be very important to the management team. For instance, in some districts the use by GPs of expensive diagnostic services is growing rapidly and implementation of policies of restraint may require co-operation from GPs.

Table 9.16 shows that few GPs reported undertaking any sorts of persuasive activity in an attempt to encourage implementation of agreed policies by GPs. Two-thirds of the GP members had not undertaken any activity to encourage implementation of policies and less than one third had undertaken any activities at all. Examples of such persuasive activities included writing a circular letter to all GPs in the district informing them of a new policy and requesting their support or introducing and persuading members of a DMC/AMC, or Local Medical Committee to support an agreed policy.

There was a certain amount of evidence in the interview material that some GPs took part in negotiations with GPs over questions of the arrangements for attached nursing or community staff although examples were rare since the GP was placed in an invidious position vis a vis his fellow GP.

The main reasons why GP team members have not undertaken activity to persuade their colleagues to support management team policies are two-fold. The structure and organisation of general practice are such that the GP team member, with a limited commitment to the position, is not able to undertake such a task. Secondly many management teams have not agreed policies which require GP participation to implement since they have focussed on the more expensive hospital services. This point was recognised in the Grey Book,

> Consultants by the nature of their work will have a greater need to co-ordinate their demands on resources than general practitioners, who must, however, also be given an equal opportunity to influence changing policies which can affect their mode of work and potential load.
>
> (DHSS, 1972, para. 4.6)

Nonetheless it was recognised that GPs are affected by team policies which concern the organisation of work.

9.7 Summary

The empirical survey showed clearly that team membership involved a substantial commitment by the GP and resulted in pressures within the partnership. Even so this commitment was limited in tenure and in scope since it was primarily a subsidiary activity. In many cases team membership was an onerous activity and replacements could be hard to find.

The evidence of informal contact between GP team member and the other members of the team supported the idea that the GP was a marginal member who relied upon the Administrator in a somewhat one-sided relationship. His contribution to team business was likely to be infrequent, idiosyncratic but nonetheless important if the other team members could take his experience into account. Many of the GP team members espoused instrumental attitudes to team membership which were partly due to the fact that he was the representative of a single 'specialty' while the consultant represents a wide range of hospital specialties. Some GPs appeared to see themselves as the advocate of community rather than hospital services or primary care.

The GP team member acted as a representative of the team as well as a representative of his colleagues in contacts with the advisory and professional committees although there was little evidence of the GP trying to persuade his colleagues to support team policies.

The next chapter examines the operation of the management team considering the input to the policy process, the mechanisms by which business is conducted, forms of decision-making, and the output of team policies.

Table 9.1 GP team members' estimation of the time they spend each week on DMT/AMT activities
(percentages in brackets)

Hours per Week	GP team members DMT		GP team members AMT		Total	
1	1	(1.3)	-		1	(1.1)
2	3	(4.0)	-		3	(3.4)
3	5	(6.6)	2	(14.3)	7	(7.9)
4	13	(17.3)	1	(7.1)	14	(15.7)
5	7	(9.3)	1	(7.1)	8	(9.0)
6	10	(13.3)	2	(14.3)	12	(13.4)
7	9	(12.0)	1	(7.1)	10	(11.2)
8	5	(6.6)	2	(14.3)	7	(7.9)
9	5	(6.6)	1	(7.1)	6	(6.7)
10	8	(10.6)	2	(14.3)	10	(11.2)
11	1	(1.3)	-		1	(1.1)
12	6	(8.0)	1	(7.1)	7	(7.9)
13	-		-		-	
14	1	(1.3)	1	(7.1)	2	(2.2)
No Answer	1	(1.3)	-		-	
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards

GP team member question 19.

Table 9.2 GP team members' estimation of the time they spend each week on management team activities

(percentages in brackets)

Hours per Week	GP team members DMT		GP team members AMT		Total	
1 - 5 hours	29	(38.7)	4	(28.6)	33	(37.1)
6 - 10 hours	37	(49.3)	8	(57.1)	45	(50.5)
11 or more hours	8	(10.6)	2	(14.2)	10	(11.2)
No Answer	1	(1.3)	-		1	(1.1)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards

GP team member question 19.

Table 9.3 Length of the term of office of GP members of district/area management teams

(percentages in brackets)

	GP team members DMT		GP team members AMT		Total	
Less than 1 year	3	(4.0)	2	(14.3)	5	(5.6)
1 - 2 years	3	(4.0)	-		3	(3.4)
More than 2 years	47	(62.6)	4	(28.6)	51	(57.3)
Unspecified term of office	22	(29.3)	7	(50.0)	29	(32.6)
Other	-		1	(7.1)	1	(1.12)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 13.

Table 9.4 Frequency of DMC/AMC and DMT/AMT meetings

(percentages in brackets)

	DMC		AMC		DMT		AMT	
Weekly	-		-		26	(34)	10	(50)
Fortnightly	-		-		41	(54)	8	(40)
Three weekly	-		-		2	(3)	1	(5)
Monthly	27	(44)	7	(39)	7	(9)	1	(5)
Two monthly	18	(29)	3	(17)	-		-	
Three monthly	12	(19)	5	(28)	-		-	
Other (on regular basis)	2	(3)	1	(5)	-		-	
As required	3	(5)	2	(11)	-		-	
Total	62	(100)	20	(100)	76	(100)	20	(100)

District Medical Committee Secretary question 6.
District Administrator question 7.

Table 9.5 Length of management team meetings in hours

(percentages in brackets)

Length in hours	District Management Team		Area Management Team		Total	
No Answer	2	(2.6)	-		2	(2.1)
1	4	(5.3)	-		4	(4.2)
2	24	(31.6)	9	(45.0)	33	(34.3)
3	35	(46.0)	9	(45.0)	44	(45.8)
4	8	(10.5)	2	(10.0)	10	(10.4)
5	3	(3.9)	-		3	(3.1)
Total	76	(100)	20	(100)	96	(100)

Percentages calculated downwards

District Administrator question 8.

Table 9.6: Frequency with which the administrator claimed to contact other members of the management team

(percentages in brackets)

Team Member	Frequently	Sometimes	Seldom	Never	None	Total
District Finance Officer	89 (92.7)	7 (7.3)	-	-	-	96 (100)
District Nursing Officer	80 (83.3)	13 (13.5)	3 (3.1)	-	-	96 (100)
District Community Physician	62 (64.6)	28 (29.2)	5 (5.2)	-	1 (1.0)	96 (100)
General Practitioner	11 (11.5)	52 (54.2)	31 (32.3)	2 (2.1)	-	96 (100)
Consultant	41 (42.7)	50 (52.1)	5 (5.2)	-	-	96 (100)

Percentages calculated across

District Administrator question 19.

Table 9.7: Frequency with which administrators claimed to contact other members of the management team

Team Member	Frequently		Sometimes		Seldom		Never		None		Total	
	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT
District Finance Officer	70	19	6	1	-	-	-	-	-	-	76	20
District Nursing Officer	64	16	9	4	3	-	-	-	-	-	76	20
District Community Physician	46	16	24	4	5	-	-	-	1	-	76	20
General Practitioner	0	11	52	-	22	9	2	-	-	-	76	20
Consultant	37	4	36	14	3	2	-	-	-	-	76	20

Table 9.8: Frequency with which administrators claimed to contact other members of the management team expressed as percentages

Team Member	Frequently		Sometimes		Seldom		Never		None		Total	
	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT
District Finance Officer	92.1	95	7.9	5	-	-	-	-	-	-	100	100
District Nursing Officer	84.2	80	11.8	20	3.9	-	-	-	-	-	100	100
District Community Physician	60.5	80	31.5	20	6.6	-	-	-	1.3	-	100	100
General Practitioner	-	55	68.4	-	28.9	45	2.6	-	-	-	100	100
Consultant	48.6	20	47.4	70	3.9	10	-	-	-	-	100	100

District Administrator question 19.

Table 9.9: Frequency with which GP team members claimed to contact other members of management team (percentages in brackets)

Team Member	Frequently	Sometimes	Seldom	Never	None	N.A.	Total
District Administrator	39 (43.8)	42 (47.2)	6 (6.7)	2 (2.3)	-	-	89 (100)
District Finance Officer	6 (6.7)	33 (37.1)	38 (42.7)	11 (12.4)	-	1 (1.1)	89 (100)
District Nursing Officer	11 (12.4)	39 (43.8)	34 (38.2)	5 (5.6)	-	-	89 (100)
District Community Physician	22 (24.7)	38 (42.7)	24 (27.0)	4 (4.5)	1 (1.1)	-	89 (100)
Consultant	28 (31.5)	41 (46.1)	16 (18.0)	2 (2.2)	-	-	89 (100)

Percentages calculated across.

GP team member question 22.

Table 9.10: Frequency with which GP team members perceived to be contacted by other team members (percentages in brackets)

Team Member	Frequently	Sometimes	Seldom	Never	None	Total
District Administrator	35 (39.3)	46 (51.7)	8 (9.0)	-	-	89 (100)
District Finance Officer	7 (7.9)	14 (15.7)	49 (55.1)	19 (21.3)	-	89 (100)
District Nursing Officer	13 (14.6)	24 (27.0)	41 (46.1)	11 (12.3)	-	89 (100)
District Community Physician	17 (19.1)	41 (46.1)	23 (25.8)	7 (7.9)	1 (1.1)	89 (100)
Consultant	19 (21.3)	40 (44.9)	25 (28.1)	5 (5.7)	-	89 (100)

Percentages calculated across.

GP team member question 23.

Table 9.11: Frequency with which district/area administrator claimed to be contacted by other members of the management team

Team Member	Frequently		Sometimes		Seldom		Never		None		No Answer		Total	
	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT
District Finance Officer	66	18	9	1	1	1	-	-	-	-	-	-	76	20
District Nursing Officer	64	16	8	4	3	-	1	-	-	-	-	-	76	20
District Community Physician	42	14	25	5	7	1	-	-	1	-	-	-	76	20
General Practitioner	7	-	38	9	28	9	-	2	-	-	-	-	76	20
Consultant	37	4	31	13	7	2	-	1	-	-	1	-	76	20

Table 9.12: Frequency with which administrators claimed to be contacted by other members of the management team expressed as percentages

Team Member	Frequently		Sometimes		Seldom		Never		None		No Answer		Total	
	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT	DMT	AMT
District Finance Officer	86.8	90	11.8	5	1.3	5	-	-	-	-	-	-	100	100
District Nursing Officer	84.2	80	10.5	20	3.9	-	1.3	-	-	-	-	-	100	100
District Community Physician	55.2	70	32.9	25	9.2	5	-	-	1.3	-	-	-	100	100
General Practitioner	9.2	-	50	45	36.8	45	-	10	-	-	-	-	100	100
Consultant	48.7	20	40.8	65	9.2	10	-	5	-	-	1.3	-	100	100

District Administrator question 20.

Table 9.13: Frequency with which GP team members and administrators present papers for discussion at management team meetings
(percentages in brackets)

	District/Area Administrators		GP Team Member	
Frequently	78	(81.25)	3	(3.4)
Sometimes	17	(17.7)	31	(34.8)
Seldom	-		32	(35.9)
Never	-		16	(18.0)
As Required	1	(1.0)	-	
Not Applicable	-		6	(6.7)
No Answer	-		1	(1.1)
Total	96	(100)	89	(100)

Percentages calculated downwards

District Administrator questions 10, 11.
GP team member questions 17, 18.

Table 9.14: Frequency GP team members report raising items at district/area medical committee meetings
(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
No Answer	-		1	(7.1)	1	(1.12)
Frequently	27	(35.9)	2	(14.3)	29	(32.6)
Sometimes	33	(43.9)	4	(28.6)	37	(41.6)
Seldom	10	(13.3)	4	(28.6)	14	(15.7)
Never	1	(1.3)	3	(21.4)	4	(4.5)
Not Applicable	4	(5.3)	-		4	(4.5)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 11.

Table 9.15: Frequency with which clinical team members raise issues at district/area medical committee for discussion

(percentages in brackets)

	District Medical Committee		Area Medical Committee		Total	
Frequently	31	(49.9)	6	(33.3)	37	(46.25)
Sometimes	24	(38.7)	8	(44.4)	32	(40.0)
Seldom	6	(9.6)	3	(16.6)	9	(11.25)
Never	1	(1.6)	1	(5.5)	2	(2.5)
Total	62	(100)	18	(100)	80	(100)

Percentages calculated downwards.

District Medical Committee question 23.

Table 9.16: GP team members' reports of undertaking persuasive activity to ensure implementation of policies

(percentages in brackets)

	Members of DMTs		Members of AMTs		Total	
Yes	21	(27.9)	7	(50.0)	28	(31.4)
No	50	(66.6)	6	(42.9)	56	(62.9)
No Answer	0		1	(7.1)	1	(1.12)
Not Applicable	4	(5.3)	0		4	(4.5)
Total	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 10.

CHAPTER TEN

THE MANAGEMENT TEAM

10.1 Introduction

The management team forms the focus of the activities of the clinical representatives discussed in this thesis. The term management is ambiguous and its use does not imply that the clinical team members manage their colleagues except in the sense that the team 'manages' part of the organisational environment in which GPs and hospital doctors work and the resources available to them. The rule of consensus, currently being challenged through suggestions of a chief executive, ensures that the clinical team members must be minimally committed to proposals before they are accepted as team policy. Consequently the team members will hold expectations of each other based on this relationship of dependency.

The last chapter focussed upon the role of the GP team member identifying the nature of the role in relation to other team members, the distinct contribution of the GP, the GP's personal objectives and his role as a representative of the team. This chapter examines the activity of the management team looking at the policy-making process, the resolution of conflict, and the communication of team policies and decisions. It is suggested throughout that the natural focus of team activity is upon secondary services because of the structure and financing of health services.

10.2 Inputs to the Management Team Policy Process

In the previous chapter the contribution of the GP member and the administrator to team business was examined. It was found that the majority of GPs seldom presented papers to the team and that their proposals were often based on subjective forms of evidence while the Administrator acted as co-ordinator and frequently presented papers or proposals to the team. In this section the range of papers, minutes and reports which come from

outside the team are examined as inputs to the management papers.

Table 10.1 shows the bodies from which the management teams regularly received minutes or reports. Not all districts or single district areas operated Cogwheel systems and therefore the category Medical Executive Committee includes Medical Staff Committees where appropriate. The committees selected in the precoded option are predominantly medical although the Health Care Planning Teams are usually multi-disciplinary. The responses in the 'other' category largely referred to administrative committees dealing with such issues as planning and finance and composed of officers.

Few teams received minutes from single-specialty committees such as Cogwheel divisions whether they concerned general practice or hospital specialties. Only three per cent of management teams received minutes or reports from the Family Practitioner Committee and the corresponding figure for the Local Medical Committee was five per cent. Only 13% of teams received minutes from the Cogwheel Divisions and these were largely in the health districts. The majority of teams received minutes from the District or Area Medical Committee (64%) and around half received minutes from the Health Care Planning Teams (54%) and the Medical Executive Committee (55%). It is not surprising that management teams seldom receive minutes from the Cogwheel Divisions since these divisions are usually directly related to an executive or Medical Staff Committee. Likewise it is surprising that more teams did not regularly receive minutes from the Health Care Planning Teams which are directly concerned with one of the key tasks of the team.[1] The vast majority of management teams received no minutes directly from bodies concerned with General Practice. This means that the GP member is largely responsible for raising issues concerning general practice if they do not arise through the DMC/AMC minutes. It is not surprising that GPs have been most vocal in their support for the retention of the District

Medical Committee since it is the only body at the district level on which GPs are represented in significant numbers.[2] There were several instances where there was a token GP on a hospital medical committee. It is clear that many Medical Executive Committees have independent access to the team since their minutes are regularly 'received' by the team. These committees represent the range of hospital specialties and often have a GP member but are primarily concerned with aspects of hospital services.

The finding that 65% of committees regularly receive minutes from a range of 'other' committees refers to the administrative and ad hoc committees responsible for many large projects and also for ongoing activities such as forward and operational planning. Much of their business stems from the wider environment in which the management team operates and includes items originating from national and regional levels. Such items often come in the form of circulars and policy documents whose local implications and impact require careful team consideration.

These minutes form much of the background information which management teams require but they also contain specific proposals which frequently form part of the decision-making agenda and may constitute expectations for action by the team. For instance, the minutes of a Cogwheel Division may include proposals for the development of the service which have resource implications and affect the balance of services within the district. A service division such as pathology may attempt to limit its workload by restricting access for diagnostic tests which has implications for GPs and hospital doctors. These formal proposals are not the only means by which specialty groups may attempt to obtain resources but they are one means of raising issues for the management team and as such have a significant role.

Another means by which items are raised on the management team agenda was through papers presented by team members. Table 10.2 shows that the sample of administrators claimed to produce papers frequently in about 80% of cases and sometimes in a further 20% of cases. The question reflects managerial style but there can be no doubt that the Administrator plays a very important role in raising issues for the team agenda. It was noted above that the GP team member produced papers less frequently but this was not surprising given the resources available to a practising GP for such tasks (see page 237). In the following section the means by which management teams conducted their business is discussed.

10.3 The Conduct of Team Business

As a consensus management team the DMT or AMT must produce decisions which are acceptable to each member and capable of implementation within the district. This section examines the processes by which the team works with particular reference to the role of the GP member.

As a team of six people the DMT or AMT does not resemble a larger committee such as the Local Medical Committee in terms of the formality of its proceedings. The Administrator is recognised to have a co-ordinating and servicing role and usually plays an important role in the creation of the team agenda, although this agenda needs to be sufficiently flexible to fit the task of operational management. Table 10.2 shows that both District and Area Administrators reported that they frequently or sometimes produced papers for team discussion. They may be assisted in this role by the 'chairman' of the team if there is one. Two-thirds of teams had chairmen and this role differs from that of a committee chairman since he cannot have the same powers of direction or a casting vote (see Table 10.3). The chairmen usually operated in a facilitating role by attempting to assist the team in reaching agreements. Approximately one-fifth of DMTs and AMTs

have a system whereby the chairmanship rotates among team members and this may or may not include the clinical members (see Table 10.4). Chairmanship frequently involves acting as the 'spokesman' for the team which may be an onerous task. Rotating chairmanship frequently lasted for a short period of months before passing to another member. Table 10.5 shows that 43% of all teams had a chairman appointed for less than one year. In one team where the clinical members were included in the rotation the GP member reported that only as chairman did he begin to understand the business of the team. Inevitably chairmanship involved further commitment of time and effort.

The sample of administrators were asked how many team members had previously been chairman. This was intended to examine the range of team members who had been chairman and also the extent of rotation. Table 10.6 shows that while a third of teams had no chairman, 28% had only had one chairman. At the other extreme seven per cent of teams had had six members as chairman suggesting that in some cases a complete 'rotation' may have taken place. If the teams with no chairman are excluded it is found that 68% of teams had had one or two chairmen and the remainder had had from three to six (see Table 10.7).

It is apparent from Table 10.8 that the most likely chairman at the time of the survey was the administrator and the next most likely were the consultant and the GP members. Nurses, Finance Officers, and Community Physicians were relatively unlikely to be team chairman. In 37% of teams one of the clinical members of the team was chairman at the time of the survey. This is slightly more than would be expected if each team member had an equal chance of becoming team chairman. While chairmanship adds to the burden of team membership it may act to prevent the clinical members becoming marginal team members, especially in the case of the GP. If the

role of the administrator in teams which have no chairman is noted, the administrator may play the key role in 58 of the 96 teams in the sample. Selecting the clinical members as chairman was sometimes described by respondents as a deliberate ploy, not related to a system of rotation, since the team wished to ensure it was sensitive to clinical problems and views or, to prevent the two clinicians from becoming marginal team members.[3]

10.4 Decision-making and Conflict Resolution on the Team

It was argued above that substantive decisions form only a small proportion of the items of business faced by a management team. They are nonetheless an important aspect of the team's activity. This section is not restricted to the analysis of such substantive decisions since agreements about position taking in relation to other agencies or the process by which to address a particular problem also require agreement from team members. The discussion deals with the strategies which management teams employed when a manifest or latent conflict within the team made resolving an issue more difficult.

Management teams are faced with two possible courses of action when a consensus decision appears improbable; resolving the issue within the team, or passing the issue to the health authority and so losing sovereignty over the decision. While the team may pass an intractable or unpopular decision to the health authority for political or strategic reasons, this was an unusual response and therefore the methods for resolving conflicts within the team will be discussed first.

The Administrator and GP member samples were asked identical questions about the methods which the teams used for dealing with conflicts of interest in policy-making. The categories used were the same as those used in

examining policy-making by the District or Area Medical Committees (see page 158). Table 10.10 compares the responses of the GP team member and the administrators and for both samples the most popular solution was characterised by the compromise strategy.[4] Several respondents pointed out that this did not necessarily imply a weak compromise. For instance, administrator 012 commented,

> ... we resolve differences by not dropping a topic until we get a viable consensus, this is not the same as a compromise but could sometimes be so.

This response suggests that the work of the management team may be difficult and that there are strong peer pressures amongst the teams to reach viable consensus. Additionally administrator 22 emphasises the nature of consensus decisions,

> A consensus decision may or may not involve compromise by a member. If a member will not compromise then the other team members must agree with him.

It follows that peer pressure may be exercised upon one member who is expected by his team colleagues to compromise. The respondent's reply did not countenance the possibility of a failure to find agreement.

Administrator 51 argued that consensus did not necessarily imply compromise and that consensus involved exploration and negotiation and frequently led to better decisions. Nevertheless these respondents indicate that arriving at consensus was sometimes a difficult business which required a certain flexibility by team members to move, by negotiation, to an acceptable solution.

The administrators recognised a wider range of strategies for dealing with conflict than the GP team members. Table 10.11 shows that 52% of Administrators mentioned using four or five strategies while the corresponding proportion of GP members was 19%. Table 10.10 shows that the Administrators more readily identified the reliance upon a specialist

decision or the 'non-decision-making' options of deferring the issue or agreeing to differ upon an issue than the GP team members. Only two administrators and no GP team members mentioned that they avoided contentious issues. Two-thirds of administrators and two-fifths of the GP members mentioned that the chairman anticipated contentious issues and steered the other members around such matters. It would be surprising if such matters could not be identified in advance especially where the team was faced with differences between the clinical team members whose room for manoeuvre on difficult topics may be limited.

The differences between the responses of GP members and administrators lay chiefly in the fact that the GPs appeared to perceive a narrower range of means of resolving conflict than the Administrators who reported using a wide range of strategies. This was in part attributed to the different ideological bases of work since Administrators might be expected to be experts in the areas of policy-making and management decision-making while clinical members were foremost practising doctors with a subsidiary involvement in team management.

A simple attempt to discover the respondents' views of the significance of the conflict resolution strategies was undertaken by asking Administrators and GP members to identify the method of resolving conflict which best described their team (see Table 10.12). Almost 19% of the Administrators were unable or unwilling to identify one method and the most popular method identified by both groups of respondents was the compromise decision (61% of Administrators, 77% of GP members). Seven Administrators responded that one member steered the team around the issue and a further six mentioned that they abided by the views of the specialist in that particular issue. Similarly six GP members also selected the specialist decision option which suggests that many items of conflict were seen as soluble using technical

rather than political criteria. In other words the issue was perceived as requiring the best technical solution rather than negotiation between members with political interests in an issue as is implied by the compromise option. There were no significant differences between District and Area Management Teams although the only expected difference might be expected in the degree to which issues were referred to the health authority.

Where they were unable to reach a consensus decision, management teams were expected to refer matters to the health authority for arbitration or decision (DHSS, 1972, para.2.42). It was widely thought that teams would not use this means of decision-making since it would involve losing 'sovereignty' over the decision. An item might in principle be referred to the health authority for at least three reasons: simple inability to come to a decision by all members; the use of a 'veto' by one member; or a political ploy to pass on the responsibility for an unpopular decision. Both GP team members and Administrators were asked whether they had referred an issue to the health authority or whether they had exercised their 'veto'. Table 10.13 shows that 45% of Administrators and 65% of GPs claimed that their teams had referred issues to the health authority for decision. There was little significant difference between members of District or Area Management Teams on this issue (Tables 10.14 and 10.15). It was difficult to account for the difference between GPs and Administrators in terms of the length of team membership since the sample of Administrators had served on the team for longer than the sample of GP members (see Tables 10.16 and 5.7). It was clear that at least a third of teams reported by each category had never referred an issue to the health authority.

Eight Administrators commented on their experience of referring issues to the health authority and five indicated that the action was not repeated since they were unable to get a suitable decision. One Administrator admitted undertaking a deliberate ploy in an attempt to make the Area Health Authority consider an issue while another employed the strategy when the clinical members could not agree over closure of a hospital and the creation of hospital practitioner grade posts. This again emphasises the difficulties for the team which may arise where the clinical member is unable to compromise a view held strongly by his fellow doctors.

Tables 10.17 and 10.18 show that 28% of Administrators reported having used their veto while the corresponding figure for GP members was 13%. This supports the view that the Administrator played a central role in team business while many GPs were characterised by a relatively marginal role although this did not prevent them standing up for special interests. Table 10.19 shows that only one GP member of an AMT reported having used his power of veto while the corresponding figure for members of DMTs was eleven. The only significance lies in the small number of GP team members exercising the veto on behalf of their fellow GPs.

It was not possible to assess the impact of the management team policy which emerged through some of the processes described in this thesis but it is important to discuss the processes by which the decisions and policies of the teams were communicated to other individuals and committees. The means by which GPs were informed about team policies and issues under discussion is dealt with in chapters 5 and 8 and the next section concentrates on the formal mechanisms such as the distribution of minutes and reports.

10.5 The Output of Team Policy

The purpose of the management team is to perform the co-ordination and planning of health services which goes beyond the responsibilities of any single team member. The team is not to interfere in the task of a chief officer who rightly manages administration, nursing, finance or community medicine but to co-ordinate the work of the hierarchically organised sections of the NHS and the medical profession (DHSS,1972, para. 2.16). The strategy of co-optation was designed to assist in the determination of agreed policies which can be implemented. The sample of administrators were questioned about how policies and decisions were communicated to the doctors who we have argued play an important part in their implementation.

Table 10.20 shows that 90% of management teams produced minutes or reports of their activities and there was no significant difference between DMTs and AMTs. Minutes are not the only way in which decisions are communicated and implemented since many policies are implemented through the four chief officers' own departments. Minutes are however a significant way in which policies are communicated to those who are not directly managed by the chief officers. Table 10.21 shows that minutes were usually sent to other professional or administrative committees rather than to individuals. Only 10% of teams sent minutes directly to the GPs within their district or area while 53% sent minutes directly to the District or Area Medical Committee.[5] Again the close link between the management team and the Medical Executive Committee was clear since 49% of teams sent minutes to these committees while only 15% sent minutes to the Local Medical Committee and only 13% to the GP committee. Additionally 35% of teams sent appropriate minutes or reports to the Cogwheel Committees. The survey of practising GPs showed that only 20% of GPs reported receiving copies of management team minutes and therefore suggests that the majority of GPs had little knowledge of local DMT or AMT policies (see Table 10.22).

These findings suggest firstly that the ordinary GP was seldom informed of management team policies as a routine matter and that the management team needed to make special arrangements to contact GPs if particular policies required their participation to ensure implementation. It is reasonable to infer that hospital doctors were relatively well informed about district or area policies through the Medical Executive Committee and the Cogwheel System or else the Medical Staff Committee. This suggests strongly that the relationship with the representative committees of hospital doctors were stronger than those between the team and local GPs. Since few GPs were informed of the activities of the management team, the findings that GPs are relatively ignorant about the operation of the management team and also show little knowledge of current issues on the policy 'agenda' are not surprising.

It follows that while hospital doctors may be well informed about management matters through the advisory system of divisions, Medical Executive and Medical Staff Committees, GPs are frequently not involved in such formal committee activity and special effort needs to be made if they are to have sufficient knowledge of the policy agenda to be able to send informed expectations to their representative. The participation of GPs in the advisory system requires that they are able to obtain information on issues under discussion and also on the team response to advice offered by the medical advisory committees. Those GPs who do not belong to the DMC/AMC or other GP committees are dependent upon informal mechanisms for receiving 'feedback' of team activity. The role of the GP team member as representative is discussed in the next chapter which includes his role in providing information for and consulting his fellow GPs within the district.

10.6 Summary

The survey was confined to formal inputs coming from within the district or area. There are a wide range of other influences which originate in the wider environment, particularly the DHSS and the RHA of which the management team must be concerned which affect the content of team business.[6] Management teams receive reports and minutes from the hospital medical committees far more frequently than from GP committees and therefore GPs were largely restricted to using the District or Area Medical Committee for making their views known. In consequence the GP team member needs to be aware of GP views and this is usually achieved through personal, informal mechanisms, such as cross-membership with other committees, through the Local Medical Committee and the GP committee. It is not argued that formal mechanisms are superior to informal mechanisms simply that hospital doctors' views and expectations reach the management team by both means while GPs are largely dependent upon the GP team member who it was argued above tended to act as a marginal team member.

While no team member acted as the managerial superior of another, the Administrator played a central role as the co-ordinator and frequently as chairman. Rotating systems of chairman were used to emphasise the formal equality and the clinical members were the next most likely chairman after the Administrator. As chairman the clinical members burden is very heavy although the benefits are that he is unlikely to remain a marginal member.

The question of decision forms the essence of management team meetings although these are not limited to substantive decisions. The importance of the compromise option suggests that many decisions are regarded, at least implicitly, as political and therefore require considerable negotiation to provide consensus outcomes. Administrators showed a wider appreciation of

strategies for resolving conflict which is to be expected in the light of their training and pattern of work. Reference to the health authority was infrequent and sometimes indicated a political ploy to influence Area Health Authority activity. The use of individual vetos was infrequent although Administrators acknowledged the importance of non-decision making strategies.

While the team is able to enforce many of its policies using conventional bureaucratic mechanisms its implementation of policies regarding clinical practice require the co-operation of doctors. Formal mechanisms of communication exist with the Medical Executive and Medical Staff Committees in many districts and single district areas but the relationships with GPs are usually mediated informally through GP team members since in most districts or areas GPs do not have an appropriate representative committee. These formal relationships in the hospital service recognise the significance of budgetary mechanisms and questions of formal accountability but the role of the GP in creating demand for district services is frequently unnoticed.

Table 10.1: Committees whose minutes are received regularly in management team agendas

(percentages in brackets)

Receive Minutes From	District Management Team		Area Management Team		DMT/AMT	
Family Practitioner Committee	2	(2.6)	1	(5)	3	(3.1)
Local Medical Committee	5	(6.6)	-		5	(5.2)
District/Area Medical Committee	59	(77.6)	3	(15)	62	(64.6)
Health Care Planning Teams	46	(60.5)	6	(30)	52	(54.2)
Cogwheel Divisions	12	(15.8)	1	(5)	13	(13.5)
Medical Executive Committee	46	(60.5)	7	(35)	53	(55.2)
Others	52	(68.4)	11	(55)	63	(65.6)
Total	76	(100)	20	(100)	96	(100)

District Administrator question 10.

Table 10.2: Frequency with which district and area administrators report producing papers for the management team

(percentages in brackets)

	District Administrator		Area Administrator		Total	
Frequently	62	(81.5)	16	(80)	78	(81.25)
Sometimes	14	(18.5)	3	(15)	17	(17.7)
Seldom	-		-		-	
Never	-		-		-	
As Required	-		1	(5)	1	(1.0)
Total	76	(100)	20	(100)	96	(100)

District Administrator question 11.

Table 10.3: Management team chairmanship in districts and single-district areas

(percentages in brackets)

Does DMT/AMT have Chairman	District Management Team		Area Management Team		Total	
Yes	52	(68.4)	13	(65)	65	(67.7)
No	24	(31.6)	7	(35)	31	(32.3)
Total	76	(100)	20	(100)	96	(100)

Percentages calculated downwards

District Administrator question 2.

Table 10.4: Method by which chairman of the management team is selected

(percentages in brackets)

Means of Selection	District Management Team		Area Management Team		Total	
Election	37	(48.6)	5	(25)	42	(43.7)
Rotation	12	(15.7)	5	(25)	17	(22.3)
Another	3	(3.9)	3	(15)	6	(6.2)
Not Applicable	24	(31.5)	7	(35)	31	(40.8)
Total	76	(100)	20	(100)	96	(100)

Percentages calculated downwards

District Administrator question 5.

Table 10.5: Length of appointment of chairman of management team

(percentages in brackets)

Length of Tenure	District Management Team		Area Management Team		Total	
1 year or less	33	(43.4)	8	(40)	41	(42.7)
1 to 2 years	2	(2.6)	1	(5)	3	(3.1)
2 years or more	3	(3.9)	-		3	(3.1)
Unspecified	13	(17.1)	4	(20)	17	(17.7)
Other	1	(1.3)	-		1	(1.0)
Not Applicable	24	(31.6)	7	(35)	31	(32.3)
Total	76	(100)	20	(100)	96	(100)

Percentages calculated downwards.

District Administrator question 6.

Table 10.6: Number of members who have been chairman of the management team

(percentages in brackets)

Number of Members	District Management Teams		Area Management Teams		Total	
No Answer	2	(2.6)	1	(5)	3	(3.1)
1	22	(28.9)	5	(25)	27	(28.1)
2	14	(18.4)	3	(15)	17	(17.7)
3	3	(3.9)	-		3	(3.1)
4	3	(3.9)	-		3	(3.1)
5	2	(2.6)	2	(10)	4	(4.2)
6	6	(7.9)	1	(5)	7	(7.3)
Not Applicable	24	(31.6)	8	(40)	32	(33.3)
Total	76	(100)	20	(100)	96	(100)

1. One Area Administrator replied that the chairman of the AHA also acts as team chairman.

Percentagees calculated downwards.

District Administrator question 4.

Table 10.7: Number of members who had been chairman of management teams (excluding teams with no chairman) (percentages in brackets)

	District Management Teams		Area Management Teams		Total	
No Answer	2	(3.8)	1	(8.3)	3	(4.7)
1	22	(42.3)	5	(41.6)	27	(42.2)
2	14	(26.9)	3	(24.9)	17	(26.6)
3	3	(5.8)	-		3	(4.7)
4	3	(5.8)	-		3	(4.7)
5	2	(3.8)	2	(16.6)	4	(6.25)
6	6	(11.5)	1	(8.3)	7	(10.9)
Total	52	(100)	12	(100)	64	(100)

Percentages calculated downwards.

District Administrator question 4.

Table 10.8: Member who is currently chairman of management team (percentages in brackets)

Chairman of DMT/AMT	District Management Teams		Area Management Teams		Total	
District/Area Administrator	22	(42.3)	4	(31)	26	(40.0)
District/Area Finance Officer	3	(5.7)	2	(15)	5	(7.7)
District/Area Nursing Officer	2	(3.8)	2	(15)	4	(6.1)
District/Area Community Physician	5	(9.6)	-		5	(7.7)
GP Member	8	(15.4)	3	(23)	11	(16.9)
Consultant Member	12	(23.0)	1	(8)	13	(19.9)
Chairman Area Health Authority			1	(8)	1	(1.5)
Total	52	(100)	13	(100)	65	(100)

Percentages calculated downwards.

District Administrator question 3.

Table 10.9: Methods used to deal with conflict by district and area management teams reported by administrators

(percentages in brackets)

Method	District Management Team		Area Management Team		Total	
Steer Around	53	(69.7)	11	(55)	64	(66.6)
Avoid Issue	1	(1.3)	1	(5)	2	(2.1)
Find compromise	74	(97.4)	19	(95)	93	(96.9)
Agree to Differ	39	(51.3)	13	(65)	52	(54.2)
Defer Issue	42	(55.3)	10	(50)	52	(54.2)
Abide by Specialist Decision	52	(68.4)	14	(70)	66	(68.7)
	76		20		96	

District/Area Administrator question 12.

Table 10.10: Methods used to deal with conflict by management team reported by administrators and GP members

(percentages in brackets)

Method	District Administrators		GP team member	
Steer Around	64	(66.6)	35	(39.3)
Avoid Issue	2	(2.1)	-	
Find Compromise	93	(96.9)	82	(92.1)
Agree to Differ	52	(54.2)	41	(46.1)
Defer Issue	52	(54.2)	35	(39.3)
Abide by Specialist Decision	66	(68.7)	36	(40.4)
Not Applicable	1	(1)	2	(2.2)
	96		89	

Percentages calculated downwards

District Administrator question 12

GP team member question 30.

Table 10.11: Number of methods used to deal with conflict on management team reported by Administrators and GP members

(percentages in brackets)

Number of Methods	District/Area Administrator		GP member DMT/AMT	
No Answer	1	(1.0)	2	(2.2)
1	5	(5.2)	14	(15.7)
2	8	(8.3)	23	(25.8)
3	32	(33.3)	33	(37.1)
4	38	(39.6)	15	(16.8)
5	12	(12.5)	2	(2.2)
Total	96	(100)	89	(100)

Percentages calculated downwards.

District Administrator question 12

GP team member question 30.

Table 10.12: Methods of dealing with conflict which best describe management team as reported by administrator and GP team members

(percentages in brackets)

Methods	District/Area Administrator		GP team members	
Steer Around	7	(7.3)	3	(3.4)
Avoid Issue	1	(1.0)	-	
Final Compromise	59	(61.4)	69	(77.5)
Agree to Differ	3	(3.1)	2	(2.2)
Defer Issue	2	(2.1)	3	(3.4)
Abide by Specialist Decision	6	(6.2)	6	(6.7)
No Answer	5	(5.2)	2	(2.2)
None/Multiple Response	13	(13.5)	4	(4.5)
Total	96	(100)	89	(100)

Percentages calculated downwards.

District Administrator question 13

GP team member question 31.

Table 10.13: Number of GP members and administrators commenting that the team had referred issues to the area health authority for resolution

(percentages in brackets)

	GP team member		District Administrators	
Referred Issue to AHA	58	(65.2)	43	(44.8)
	89	(100)	96	(100)

District Administrator question 14

GP team member question 32.

Table 10.14: Number of district/area management teams which had referred issues to the area health authority

(percentages in brackets)

	District Management Teams		Area Management Teams		Total	
Referred Issue to AHA	33	(43.4)	10	(50)	43	(44.8)
	76	(100)	20	(100)	96	(100)

District Administrator question 14.

Table 10.15: Number of teams which had referred issues to the area health authority

(percentages in brackets)

	District Management Teams		Area Management Teams		Total	
Referred Issue to AHA	49	(66.2)	9	(60)	58	(65.2)
	74	(100)	15	(100)	89	(100)

GP team member question 32.

Table 10.16: Year in which district or area administrator's appointment commenced

(percentages in brackets)

Year of Appointment	District Administrators		Area Administrators		Total	
1974	49	(64.5)	9	(45)	58	(60.4)
1975	-		-		-	
1976	2	(2.6)	1	(5)	3	(3.1)
1977	11	(14.5)	4	(20)	15	(15.6)
1978	13	(17.1)	4	(20)	17	(17.7)
1979	1	(1.3)	2	(10)	3	(3.1)
Total	76	(100)	20	(100)	96	(100)

District Administrator question 1.

Table 10.17: Number of GP team members and district/area administrators who claimed to have exercised their veto on the team

(percentages in brackets)

	GP team members		District/Area Administrators	
Exercised Veto	12	(13.5)	27	(28.1)

GP team members question 33

District Administrators question 15.

Table 10.18: Number of district/area administrators who claimed to have exercised their veto on the management team

(percentages in brackets)

	District Administrators		Area Administrators		Total	
Exercised Veto	21	(27.6)	6	(30)	27	(28.1)
	76	(100)	20	(100)	96	(100)

District Administrators question 15

Table 10.19: Number of GP team members who claimed to have exercised their veto on the management team

(percentages in brackets)

	District Management Teams		Area Management Teams		Total	
GP representatives veto	11	(14.9)	1	(6.7)	12	(13.5)
	74	(100)	15	(100)	89	(100)

GP team members question 33.

Table 10.20: Number of teams which produce and do not produce minutes

(percentages in brackets)

	District Management Teams		Area Management Teams		Total	
DMT/AMT does produce minutes	68	(89.5)	19	(95)	87	(90.6)
DMT/AMT not produce minutes	8	(10.5)	1	(5)	9	(9.4)
	76	(100)	20	(100)	96	(100)

Percentages calculated downwards.

District Administrators question 16.

Table 10.21: Committees and bodies to which team minutes are distributed

(percentages in brackets)

	District Management Team		Area Management Team		Total	
Area Health Authority	44	(57.9)	16	(80)	60	(62.5)
District/Area Medical Committee	45	(59.2)	6	(30)	51	(53.1)
Family Practitioner Committee	11	(14.4)	2	(10)	13	(13.5)
Local Medical Committee	12	(15.8)	2	(10)	14	(14.6)
Medical Executive Committee	41	(53.9)	6	(30)	47	(48.9)
Health Care Planning Teams	12	(15.8)	1	(5)	13	(13.5)
Cogwheel Committees	30	(39.5)	4	(20)	34	(35.4)
General Practitioners	9	(11.8)	1	(5)	10	(10.4)
Community Health Councils	37	(48.7)	1	(5)	38	(39.6)
Others	55	(72.4)	15	(75)	70	(72.9)
Not Applicable	8	(10.5)	1	(5)	9	(9.4)
	76	(100)	20	(100)	96	(100)

District Administrators question 17.

Table 10.22: Number of GPs receiving reports or minutes of management team meetings

(percentages in brackets)

GP Response	GP Sample	
Received minutes or reports	27	(20.3)
Not received minutes/reports	105	(78.9)
Don't Know	1	(0.75)
	133	(100)

GP sample question 21.

CHAPTER ELEVEN

THE GP TEAM MEMBER AS REPRESENTATIVE

11.1 Introduction

This chapter examines the role of the GP team member using the typology of representation developed by the Brunel Health Services Organisation Research Unit (HSORU) and modified by the author. The GP team members' view is discussed and followed by discussion of the views of other members of the role-set. The discussion moves to examine the representative aspects of the behaviour of the GP team member. The particular expectations which GPs held of their representatives are discussed in terms of immediate and strategic expectations and the changes in the pattern of expenditure taking place within the district. Finally the GPs' perceived expectations are examined - that is, the expectations which they perceive other members of the role-set as holding.

11.2 The Representative Role

The Grey Book referred to the GP member of the management team as the representative of the District or Area Medical Committee (DMC/AMC), not the representative of the districts' GPs (DHSS, 1972, para. 4.9-4.12). (This assumption has not been made in the 1982 restructuring of the service since the concept of a single, multi-specialty medical advisory committee giving the agreed views of the doctors within a district is no longer acceptable.)[1] Additionally the GP representative is a team member, or manager, sharing in the collective responsibility of the team but only accountable to his peers. The executive action required of a team member demands that the GP should be able to anticipate that he will be able to obtain the necessary support for any proposal the team adopts. If the views of the GP's peers are not clear then the GP team member is potentially placed in a stressful situation with a certain level of uncertainty.

The classification of representation developed from the BIOSS typology was presented to each category of respondent who were asked to choose a single option and comment upon their choice. This is not the ideal method of examining the generalised expectations of the GP team member's role but it did draw broad comparability across a wide range of respondents.

Table 11.1 shows the role descriptions chosen by GP team members. Firstly it was found that 13% (12) of respondents felt that none of the options accurately described their view of the role. The small number of respondents from Area Management Teams makes it difficult to identify significant variations between GP members of district and area teams. A preference was expressed for the non-negotiating role by 37% of respondents while 19% chose the negotiating role and 30% the type-representative. There was clearly no consensus among respondents although a considerably smaller proportion chose the negotiating representative role with the implication of formal authority to make decisions to which GPs were committed without reference back. The remaining two categories imply a low level of formal authority although the non-negotiating role implies the function of spokesman. The type-representative role closely resembles the concept of microcosmic representation since the relationship between representative and 'constituent' consists simply of a similar occupational status.

The same question, with one amendment, was addressed to each of the other groups of respondents to examine their generalised expectations of the GP team member. Since a number of Local Medical Committee (LMC) secretaries had indicated in informal conversations that their committee was responsible for nominating the GP team member, the categories were

modified to include the possibility of LMC nominated representatives as well as those nominated by the DMC/AMC. Table 11.2 shows that the five groups of respondents answered in a similar way to the extent that the majority in each case, except the administrators, selected the non-negotiating representative category. The first preference among the administrators was the type-representative category, closely followed by non-negotiating representative. For the samples of GPs and LMC secretaries, the elected or negotiating representative comprised the second preference. Finally the GP team members and DMC/AMC secretaries chose the type-representative in preference to the negotiating-representative role.

While it would be unwise to draw too many conclusions from this question it is clear that the non-negotiating role was the most popular choice for GPs, GP team members, LMC secretaries and DMC/AMC secretaries. This option had two elements; the elected representative appointed to speak for the District Medical Committee; and the fact that the committee does not agree to be bound by his words or actions. This option implies a very ambiguous form of authority given to the GP team member since he cannot commit those he represents to any decision and this has implications in principle for the executive action which he is party to as a team member. The Administrators' sample gave first priority to the type-representative category which clearly implied that the GP team member could not speak for or make decisions on hebalf of the GPs in his district or area. In contrast a quarter of GPs and a fifth of LMC secretaries accepted the negotiating representative authorised to make binding decisions on their behalf.

It is this aspect of representation in which the representative can speak on behalf of those he represents, anticipate their views in advance, or make decisions on their behalf which underpins the concept of co-optation. As a type-representative the GP member can simply advise the team of possible GP views on the basis of his personal views as a GP. This undoubtedly

has some value to the team but does not contribute to the integration of primary care services with the other services provided in a district or single-district area.

11.3 Activities by which GP team members attempted to discover the views of their fellow GPs

It was argued above that the GP team members face issues in which the expectations of fellow GPs or 'constituents' are ambiguous or, due to the problem of visibility, unclear.[2] It followed that GP team members would need to undertake activities to identify the views of their constituents on general or particular issues. The first category of these activities may be termed 'standard procedures' by which is meant formal, often institutionalised, means by which GPs consult various committees or groups composed of GPs within the district or area.[3] These groups may not be composed entirely of GPs and one such group is the District or Area Medical Committee. The second means by which GP team members seek the views of their fellow GPs is described as canvassing activities which refer to activities aimed at the whole constituency of GPs to find the views of each GP or to allow individual GPs to express their views.

Eighty-one per cent of GP members claimed to have undertaken some activity to discover the views of GPs in their district or area (see Table 11.3). Table 11.4 shows the means adopted by GP team members to seek the views of their constituents and includes both standard procedures and canvassing activities. There are some activities which fall between the two categories. GP Committees, GP Cogwheel Committees or GP Forums may be organised on an ad hoc basis in which case they involve canvassing about particular issues. To the extent that they are held on a regular basis, they resemble Standard Procedures for consultation or clarifying role expectations. Consultations with the Local Medical Committee or the District/Area Medical Committee fell into the category of standard procedures which are examined first.

The most important consultation procedure was consulting the Local Medical Committee chosen by 29% of team members and eight of the 14 GP members of Area Management Teams (see Table 11.4). This finding emphasises the significance of the LMC in a single-district area. In health districts 10 GP members mentioned that they consulted the District Medical Committee as a standard procedure. The next most important source of GP views were committees composed entirely of GPs. Eight respondents mentioned GP or Cogwheel committees and nine mentioned GP Forums. The GP Cogwheel Committees were 'representative committees' while the GP forums were open to all GPs practising within the district although in some districts geographical location of GPs made such committees less useful than in compact districts or areas. The GP team members of DMTs could not operate uniform standard procedures for consultation since there was no widespread system of GP representative committees in England and Wales at the district level. In many districts there was no GP committee and therefore the DMC was the only widespread representative body with GP members.

Seven GP members mentioned that they had undertaken some direct canvassing through the use of postal questionnaires or personal letters addressed to GPs. A further nine GP members mentioned that they had discussed matters with GPs on a personal basis. Finally there were 19% of respondents who replied that they had undertaken no consultative or canvassing activities to ascertain the views of GPs within the district or area.[4] Thus, four-fifths of respondents mentioned a varying range of activities by which they attempted to discover the views of other GPs within the district on a regular or occasional basis. Such consultation included a number of activities such as: seeking views upon immediate or strategic priorities; seeking information about particular circumstances or problems from a specific GP or partnership; seeking advice from an expert or experienced colleague; or seeking advice on the best means to pursue a particular objective.

GP team members were also asked to indicate the frequency with which they sought advice from individuals and groups apart from GPs within their own district or area. Table 11.5 shows that the most important source of advice was members of the Local Medical Committee with 43% claiming to seek its advice frequently and a further 37% approaching it sometimes. Only four per cent claimed that they never sought advice from LMC members. GP team members reported seeking advice from a considerable range of persons sometimes including other management teams. Family Practitioner Committee members, and the Area Team of Officers most notably. Perhaps the most important groups who were not contacted for advice were health authority members and Community Health Council members. There was evidence throughout the study of a certain hostility between some GP team members and their Community Health Councils and in larger Areas the contacts between health authority members and GP team members might be expected to be infrequent. The exception may lie in GP members of health authorities who have a different function to GP team members but might be interested in the area of primary care.

11.4 The Content of GPs' Expectations

The range of generalised expectations held by GPs of their team member was discussed above (Chapter 8.4). This section focusses on the specific expectations the GP sample held which were ascertained through four questions in the GP questionnaire.[5] It is not suggested that all these expectations necessarily constitute influence attempts and their significance within the 'representative-constituent' relationship is discussed below.

The four questions come in two parts and are concerned with the GP's views on expenditure decisions in the immediate and long-term future, and the GP's views of immediate and strategic priorities. The questions relating to priorities will be discussed first and the questions used were:

what do you think are the most important matters that the District Management Team should be considering for immediate action?; and secondly, what do you think are the most important matters that the District Management Team should be considering for future action? The distinction between the two questions was designed to enable the answers to take account of political realities such as the availability of resources and the limited timespan of GP team members tenure. The distinction between operational and strategic management and planning is widespread in the NHS and the questions were intended to take account of it. Additionally the question of strategic priorities introduces greater levels of uncertainty and might be expected to result in more optimistic and possibly costly expectations.

The responses were interpreted by listing the main themes in each answer and then examining each answer in turn to see which of the main themes were included. Simple counting was employed to give some idea of the significance of each expectation and examples are given to illustrate the main findings.

The first finding which importantly demonstrates the context in which GPs responded demonstrates the low level of knowledge which GPs had of the management team structure. For instance respondent 3017 replied,

> I confess with shame that I am almost totally ignorant of the entire field of health services management. I did not know there was a District Management Team.

In addition respondent 3033 stated that he did not know what a District Management Team was. Similar comments were made by twenty respondents suggesting that a significant proportion of GPs knew little of structure or processes of district management. Such patterns of non-involvement were explained by some respondents in ideological terms. Respondent 3045 stated that he "was not interested in medical politics" and similar views

were expressed in several letters. Medical politics appeared to include those activities which were not directly related to individual patient care.

Another element of this hostility was directed to the administrative arrangements within district or area and in some cases the assumption that they resulted in diversion of resources from clinical work. Respondent 3079 argued for,

> Their (DMT/AMTs) total abolition and the diversion of the cash spent on them to direct treatment of illness and increasing the numbers of doctors.

Eight respondents took similar views and respondent 3115 argued that District Management Teams should be superceded by Local Medical Committees. These findings emphasise that a significant proportion of respondents were relatively ignorant about the nature of local health service management. It follows that in some cases the priorities which GPs identify may be inappropriate given the limitations of power and resources at this level.

The most important immediate priorities identified by respondents for immediate action were specific care group problems, most of whom fell into the so-called Cinderella specialties. The most frequently mentioned group were the elderly and those classed as psychogeriatrics widely thought to represent the most important problem group facing the service. Many of the answers included preferred solutions either in terms of institutional or community provision. More than twenty respondents identified particular hospital services which were deficient and fifteen mentioned community services. Respondent 3111 argued,

> The geriatric facilities, with inpatient and outpatient, in this area are shamefully inadequate.

Other specific care groups were identified including maternity and psychiatric services where the problem was seen as an inadequate number of

beds. The means of caring for the elderly in the community were seen very much in terms of changes in the balance or increases in the number of community manpower available. Several respondents indicated that resources should be transferred from institutional to community forms of care. For instance, respondent 3134 argued that hospital expenditure could be cut by expanding general practice and respondent 3173 who identified the need,

> to develop a more community oriented service as opposed to an institutional one.

Many respondents assumed that immediate priorities could be met without sacrificing or cutting existing services and that management took place in the context of growing real resources. This may indicate that GPs were only slowly becoming aware of the resource situation in the NHS and faced by most districts.

The solution of service deficiencies for some respondents required an increase in the number of paramedical and nursing staff in the community. Respondent 3088 combined this with an attack on bureaucracy,

> Get rid of office wallahs. Increase community nursing facilities.

Eight other respondents also emphasised community nursing staff which demonstrated an understanding of one aspect of the management team's activities.

Five GPs saw a need for the co-ordination of primary and secondary services within the district or area. These fell largely into the area of inpatient and outpatient policies where communication between hospitals and GPs often seemed to break down. Of course GPs are dependent upon the hospital for these services. Fourteen respondents specifically mentioned waiting lists for inpatient and outpatients and GP 3029 suggested this might be achieved by,

> Reducing waiting lists by more efficient use of hospital facilities and improved communication between hospital and GP.

A similar theme was suggested by respondent 3140,

> Making a greater understanding of community function to all levels of hospital staff, medical, nursing, admin, so that patients can be more efficiently returned to the community at the best time. This has to do with communication.

While such suggestions might be criticised for failing to recognise continuing problems such as blocked beds, gaps in community and personal social services, and lack of appropriate housing for some patients they suggest that some GPs regard many of the problems of waiting lists as the result of misinformation and bad communication within the local health services.

Another respondent argued that waiting lists could be reduced by increasing the throughput of selective acute cases,

> The hospital service should be run on a 7-day week basis ie Selective surgical waiting could be almost eliminated by early discharge and 18 hours a day use of all operating theatres and use of weekends. Consultants should reduce waiting lists to something sensible ie 2-3 weeks by discharging follow-ups - too many patients keep going back every six months and seeing a new SHO - nobody discharges them.

The view that waiting lists could be reduced by more efficient use of hospital services, often managed by consultants, was widely held among GPs and clearly the length of waiting lists was a major grievance.

The last important theme for immediate consideration was the question of increasing administrative efficiency which was frequently seen as a means of increasing the resources available to the obviously efficient medical services. Nineteen respondents identified efficiency as a major goal for the management team and some respondents suggested that this goal was hindered by the excesses of functional management and the unnecessary middle tier.

In examining the immediate priorities expressed by ordinary GPs it is apparent that matters of professional and sectional interests were only indirectly noted. No more than two respondents mentioned the issues of GP access to hospital beds, diagnostic services, or hospital practitioner posts. GPs' immediate priorities for the management team, where they had sufficient knowledge to attempt answers, indicated experience of shortcomings of patient services which could be partially ameliorated by increased efficiency, co-ordination and communication between practitioners.

The second category of GP expectations concerned the long-term or strategic expectations. At the time of the survey there was considerable uncertainty about future resources due to the effects of RAWP redistribution, the reality of cash limits and the prospect of cash planning. The prospects however varied among different districts which might have been expected to influence the priorities expressed by different respondents.

A number of respondents felt unable to distinguish between immediate and long-term priorities and there was also a small proportion whose ignorance prevented them from responding. The focus remained upon the 'cinderella services' with comments that the number of elderly people was likely to grow disproportionately in the forseeable future. There was considerably more emphasis placed upon the importance of hospital services to achieve improved services. Eight respondents mentioned new District General Hospitals or redevelopments of existing hospitals and a further five saw the solution to lie in new consultant posts for particular specialties, particularly psychogeriatrics. Six respondents emphasised the importance of increasing the number of beds for particular hospital specialties thus emphasising the importance placed upon institutional care.

Eight respondents made general statements about increasing the quality of primary or community care and a further five suggested increasing the

numbers of disposition of community paramedical or nursing staff. There was a similar concern with the relationships between GPs and consultants although improvement was defined as a long-term aim and not a feature open to immediate improvement. A further eight respondents pointed to the need for continuing improvements in NHS efficiency in order to preserve the present level of services.

11.5 GP Resource Priorities

In a further attempt to discover GPs' views on the pattern of expenditure within the district the sample were asked if they believed that significant changes were required in the pattern of expenditure in their district given the present cash limits in operation. Table 8.5 shows that 43% of GPs did not believe that significant changes were required in the pattern of expenditure within the district. The remaining 50% were asked in which areas expenditure might be reduced and in which areas it might be increased. The three questions indicated that the changes were envisaged within a zero-sum situation in which the total level of resources available were limited and increases in one area required corresponding reductions in others.[6]

Two respondents professed ignorance in not identifying potential reductions in expenditure and another argued strongly that there were no possible means of reducing expenditure within his district. The remaining 55 respondents did identify possible reductions albeit in non-medical areas for the most part. The major area of reductions were identified in the field of administration. Thirty respondents pointed to particular administrative arrangements with three mentioning the area or district tier of the service. For instance, respondent 3050 advocated the 'reduction of senior administrative professionals', and GP 3072 identified,

> less expenditure on administration, structure and the various levels of red tape.

This point was also put by respondent 3188,

> I get the impression that during the past twenty years there are an increasing number of administrators running the service and the patients receive no apparent benefit from this.

There can be no doubt that a significant proportion of GPs perceived that the demands of patient care were stifled by a growing administration which appeared to result in few benefits for patients. The term administration was applied to a wide range of activities including management, operational and strategic planning, hospital administration, and also the work of doctors not engaged in individual patient care.

An associated target for reductions was the services provided by social services departments. Seven respondents identified this area and indicated either a poor understanding of the relationship between NHS and local authority services or, less likely, a radical view of health service financing. Respondent 3079 provides a good example,

> ... Also sending out social workers to vet GPs' requests for admission to 'Old Peoples Homes'. These girls are rarely out of nappies.

The respondent indicated a certain hostility to social workers based upon their position in dispensing places in residential accommodation which was a scarce resource.[7]

The next important category of possible areas for reduction in expenditure may be classified as areas of medical practice. The most important was the prescription of drugs mentioned by seven respondents in the context of hospital services and five in the context of GP services. Since the cost of GP prescriptions do not feature in the budget of the health district or single-district area, the motivation to reduce the cost of GP prescribing is low on the list of management team priorities. This was not the case with the costs of hospital prescribing. Respondent 3022 suggested,

> Patients attending hospital should have their drugs dispensed by the hospital when bulk purchasing can be used.

In fact evidence from interviews with two GP team members showed that hospitals were attempting to leave prescribing outpatients drugs to their GPs thus inconveniencing the patient but ensuring the hospital drugs bill could be controlled. Co-ordination between the hospital and the GP was regarded as an important element of efficient prescribing and two GPs mentioned the question of inefficient prescribing. GP 3168 suggested that doctors should,

> reduce the provision of useless and harmful medications: eg hypnotics and minor tranquillisers.

GP 3189 made the same point with respect to diagnostic and pathological investigations which were not absolutely necessary.

Four GPs pointed out instances of the duplication of services by hospital, clinic and GP services. Immunisation, Family Planning and Child Welfare Clinics were given as examples and it needs to be pointed out that GPs receive additional fees for some of these services. Additionally four respondents identified a need for reductions in hospital, non-medical manpower. These latter comments indicated that the originators emphasised the priority of clinical services and subscribed to the view that there were inefficiencies and areas of over-provision in the support services.

GPs found it easier to identify areas of services in which expenditure could be increased. Not surprisingly, the pattern of responses bore close resemblance to the immediate priorities discussed above. The proximity of the two questions might lead to similar responses but the inclusion of the cash limits phrase was intended to add realism to suggestions. Nineteen respondents mentioned the 'Cinderella specialties' and ten of them indicated institutional rather than community oriented solutions. For instance, GP 3034 advocated increasing the number of geriatric beds and respondent 3134

emphasised the need for acute geriatric beds. The question of phased care was suggested by GP 3074,

> Small community 'hostels' for the elderly for short stays to relieve strain upon relatives.

Similarly GP 3082 mentioned the need for more support services for the care of geriatric cases in their homes such as night sitters and home helps.

There were a handful of calls for more medical manpower of which GP 3062 is an example,

> Where there are shortages of specialists in certain fields new appointments should be made and the service to patients improved.

GP 3073 summed this up with a call for 'more medical men in hospital'. There was however much stronger support for increasing the numbers of community nursing and health visitor staff. Respondent 3015 identified as an area for increasing expenditure,

> physiotherapy, occupational therapy, nursing and geriatric care in particular

GP 3103 simply called for 'more nurses for home care'.

While GPs most frequently asked for services for the elderly there were eleven respondents who mentioned the problems of the acute services. Respondent 3009 identified the areas of general surgery, orthopaedics, ENT, gynaecology and geriatics. Several of this group related the needs to the waiting time experienced by patients referred to consultants. Respondent 3185 advocated,

> In outpatient services to enable urgent surgical cases (carcinoma etc.) to be more quickly investigated and provided with surgical treatment.

A handful of GPs felt that money should be used to find additional GPs although this suggested that they were not aware of the structure of NHS and Family Practitioner Service administration.

11.6 GP team members' perceptions of the expectations held by their fellow GPs

The sample of GP team members were asked two questions designed to discover their perceptions of the expectations held by their fellow GPs. Question seven asked "What are the main issues which the District Medical Committee wishes the District Management Team to pursue?". It was complemented by question 38 which asked, "What do you think are the most important policies which GPs would like the District Management Team to implement?". The second question was divided into immediate and long-term categories. These questions were designed to see the extent to which the GP team members' perceptions of the DMCs and their fellow GPs' views co-incided with the views expressed by the samples of DMC secretaries and GPs.

The essential difference between the questions lies in the nature of DMC/AMC expectations and that of constituent or GP expectations. As a representative committee of each of the three branches of medicine the DMC/AMC was designed as the source of agreed medical views within the district or single-district area. Indeed the GP team member was described as one of the District Medical Committee representatives. The GPs within a district have a distinct practice orientation and may be expected to have distinctive expectations, from those of other medical specialties.

DMC/AMC Expectations

Seven of the 89 GP team members who responded to the survey reported that there was no District or Area Medical Committee or that it had ceased to meet. A further three could detect no issues on which agreement had been reached which warranted team action. The majority of respondents identified issues which might be expected to be of interest to hospital doctors as well as GP members of the District or Area Medical Committee.

Accordingly most issues focussed upon hospital services and consideration of community services was of secondary importance.

A wide range of services were identified which were agreed to be priorities for increased numbers of beds or other facilities. For instance, GP member 020 mentioned the need for an acute psychiatric in-patient unit and respondent 079 mentioned policies for the development of obstetrics and accident and emergency services. Thirteen respondents identified particular hospital specialties and nine mentioned the need to increase the number of hospital doctors. Respondent 042 felt that increased staffing would protect vulnerable hospital services,

> Provision of Registrars for certain specialties which are seen to be at risk because of lack of senior staff.

Other respondents such as GP team member 090 simply stated that the DMC/AMC had agreed priorities on new consultant posts.

Nine GP team members mentioned the problem of outpatient or inpatient waiting lists and solutions were suggested in two forms. Respondent 040 replied,

> Reduce waiting lists for outpatient clinics.
> Arrange a better appointments system for outpatients clinics.

In this case the problem could be partially solved by administrative measures but respondent 043 suggested a system for identifying priorities for outpatients appointments was needed. The implication was some form of medical rationing system to accelerate the 'deserving cases' by selecting out some of the less deserving, at least temporarily. Nine other GP team members interpreted waiting lists as measures of demand for new consultant posts in those particular specialties.

An important series of DMC/AMC policies were related to plans for the provision of new hospitals, redevelopment of existing hospitals and the

elusive District General Hospitals. Such capital developments frequently have a long lead in time and can take up much of the time of a medical committee. Seven GP team members mentioned that the DMC or AMC had produced policies for the future of hospital services and a similar number mentioned major redevelopments or new District General Hospitals. Respondent 026 mentioned that the DMC had agreed policies on the future hospital services for a particular northern city and GP team member 067 mentioned that the DMC had taken part in strategic planning for two District General Hospitals. It was apparent that some GP team members saw the DMC or AMC as a pressure group which could provide ammunition for fighting for new developments especially where it involved persuading one or more health authorities. GP team member 008 stated that the DMC had agreed,

> To make sure that the plans for the building of a new Nucleus hospital are not thwarted.

This clearly goes beyond the view of the DMC as simply an advisory committee since it suggests a pluralist view of decision-making amongst competing or conflicting factions.

The next most important group of policies identified by the GP members concerned the co-ordination of primary and secondary services and the access of GPs to diagnostic equipment and hospital beds. This question of access was notable by its absence in the GP samples immediate and future priorities. Nine GP team members spoke of co-ordination between GPs and hospitals in general terms as exemplified by respondent 036,

> Improving communication between consultants, hospital departments and GPs.

More specific questions of access were identified by GP member 010 who spoke of 'an X-ray diagnostic service for GPs' and more clearly by respondent 056 whose DMC was pressing for,

1. Open radiological facilities for all GPs at <u>all</u> hospitals in the district
2. ECG at all hospitals in the district.

Four GP team members mentioned that their DMC/AMCs were pressing for GP hospitals or the retention of such hospitals which were under threat from financial cuts. A further five GP team members mentioned that the DMC/AMC had agreed policies for the employment of GPs on a sessional basis as hospital practitioners or clinical assistants. It follows that the themes of GP access to hospital facilities and GP employment in hospital medicine were perceived as important expectations of the DMC/AMCs although the sample of GPs did not give this area high priority. Not surprisingly most GP team members perceived that the DMC/AMC was interested in matters concerned with the use of hospital services, the organisation of medical work in hospitals and the degree of GP autonomy in the use of these services.

GP Expectations

GP members' answers to the question "what do you think are the most important policies which GPs would like the District Management Team to implement?" indicated that they perceived the expectations of their peers to be significantly different to those of the DMC or AMC. Their responses were similar to those of the GP sample in that they primarily identified services for the elderly which is not surprising since GP team members were practising GPs in all but two cases and therefore shared similar work positions.

Of sixteen GP team members who identified specific services fifteen mentioned the geriatric services and similarly of seventeen respondents who mentioned community services, nine mentioned services for the elderly. Most of the GPs who spoke of hospital facilities or developments in hospital services for the elderly saw the problem in terms of an inadequate number of hospital beds. Those GP team members who referred to community provision included a wide range of possible services. Respondent 046 mentioned,

> Increase in community services and paid volunteers as helpers in Geriatric services.

Another GP team member mentioned the need to co-ordinate services with those provided by other agencies,

> care within the community for the elderly and infirm by improving health, welfare and social services.

This focus on a range of services was mentioned frequently and complemented by the call for developing community staffing in nursing and paramedical services. Sixteen GP team members perceived that their peers wished for increased numbers of community staff including respondent 007,

> Increase in domiciliary services eg. direct access to physiotherapy, more district nurses, fewer health visitors.

This respondent emphasised the question of 'domiciliary' rather than the more general term 'community care' suggesting an emphasis on treating and caring for patients at home as well as preventative care and the promotion of health often seen as part of the Health Visitor's role.

The relationship between GPs and community staff was identified by GP 065 who mentioned the attachment of community staff to general practices thus giving the GP the possibility of directing their work. Nine respondents mentioned the question of waiting and respondent 001 mentioned the problem in the following way,

> To ensure shorter waiting periods for outpatients and admission. My GP colleagues monitor this very fully.

It was unusual for the GP team member to directly mention that he was expressing the views of his peers. Many appeared to assume that the priorities which they identified was also those of their peers. The other feature of waiting lists which was mentioned was the waiting time for cold surgery and in one case more urgent surgery.

Seven GPs mentioned the need to transfer resources from secondary to primary or community care. Respondent 014 perceived this transfer resulting from economic pressures and implied that community solutions were cheaper,

> All facilities to implement district responsibilities when community care becomes more manifest and hospital facilities diminish as a result of economies.

While this respondent implied the inevitable movement from secondary to primary services for some conditions others indicated that the proportion of resources allocated to the district needed to be defended. Twelve respondents felt that their colleagues wished to protect existing levels of community resources and respondent 047 saw this as a sectional interest,

> To avoid financial cuts following too heavily on those parts of the service which are most necessary to GP support, ie Maternity service, psychiatric service, geriatrics.

Such a defensive approach was spelt out even more clearly by GP member 050,

> In this district's present situation it has become susceptible to considerable reduction in service as a result of RAWP and the Regional Strategic Plan. Our policies are therefore negative and defensive to minimise the impact while needing the urgent development of a district psychiatric service.

Such a perception of the environment and GP's views enables the representative to take up a coherent position in which defence of existing services takes high priority. External circumstances are seen to limit the scope for new developments even where these are perceived as urgent.

The next category of responses concerned the issue of open access by GPs to district facilities and was mentioned by thirteen respondents. Access to such technological equipment and facilities may have significant implications for the professional status of GPs vis a vis hospital doctors. Therefore access was to be fought for and once obtained required to be defended in a hostile environment. Additionally four respondents mentioned GP employment in hospital practitioner and other posts.

11.7 GP members' perceptions of their colleagues' strategic priorities

GP team members perceived that the most important long-term objectives of their peers concerned the provision of institutional facilities for specific care groups. Fourteen of the seventeen respondents who identified such objectives mentioned geriatric or psychogeriatric services. Only seven of the respondents specifically mentioned community solutions to dealing with elderly patients and there was a tendency towards vague statements such as 'improvement of Geriatric care in the community'.[8]

Following the pattern of the immediate priorities there was an emphasis placed on the importance of community manpower mentioned in general and also more specific terms such as attachment schemes. Respondent 008 mentioned the significance of the attachment of health visitors and GP team member 059 perceived that his colleagues wished to expand the primary care team. Altogether nine respondents reported that their colleagues felt the need to expand the manpower in community services.

Not surprisingly this category resulted in optimistic views about the possibilities of hospital redevelopment, new District General Hospitals and GP or community hospitals since the time-scale was not specifically set out and long-term could be interpreted widely. Respondent 061 added a touch of cynicism in his suggestion,

> the new District General Hospital which theoretically should solve many of our problems but will probably produce many more.

Many respondents envisaged coping with increasing numbers of elderly patients by increasing the whole range of NHS facilities open to GPs. Respondent 085 was one of four who specifically mentioned a GP hospital so that GPs could have access to their 'own' beds. An additional four respondents perceived that their colleagues would like access to District General Hospital beds to enable them to cope with their patients.

Finally five respondents felt that their colleagues wanted a redistribution of funds and this was summed up by respondent 025 who advocated,

> A close look at the high cost specialties and their impact on the district budget as a whole, especially their effect on Primary Care Services.

More explicitly respondent 044 perceived that his GP colleagues wished for 'a shift of resources away from the District General Hospital into the community'.

11.8 Summary

The types of representative role selected by GP team member and other members of the role-set support the view of the representative as a spokesman who needs to be in close contact with those he represents in order to fulfil his role. The extent of his formal authority is recognised to be limited and indeed the type-representative was the most important selection amongst the sample of Administrators.

GP team members had various standard procedures for consulting their colleagues usually through the Local Medical Committee although there was some evidence that they sought advice or information from individual members of the role set at times. The expectations of practising GPs demonstrated ignorance and indifference in the activities of local NHS management in some cases. The GP sample's immediate priorities concerned the so-called Cinderella services and frequently implied increases in community nursing staff to help care for the elderly. The other main priority was the co-ordination of hospital and community services with respect to inpatient and outpatient policies which were frequently understood as a problem of waiting lists. Some GPs found it difficult to distinguish between long-term and immediate priorities but long-term policies focussed upon Capital

Developments, Consultant Posts and relationships between GPs and Hospital Specialists.

The GP team member was questioned about his perception of expectations from two sources: the District or Area Medical Committee and the GPs in his district. The DMC/AMC priorities were largely concerned with hospital beds and manpower and there was a significant interest in GPs' access to 'hospital facilities'. Strategic priorities included the transfer of funds from hospital to community services and the enhancement of general practice.

Table 11.1: Role descriptions chosen by GP members of district/area management teams

(percentages in brackets)

	GP member DMT		GP member AMT		Total	
No Answer	6	(8)	3	(21.4)	9	(10.1)
Negotiating Representative	17	(22.7)	-		17	(19.1)
Non-Negotiating Representative	28	(37.3)	5	(35.7)	33	(37.1)
Type Representative	22	(29.3)	5	(35.7)	27	(30.3)
None	2	(2.7)	1	(7.1)	3	(3.4)
	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team member question 11.

Table 11.2: Role description said to fit the role of the GP member of management team most closely by other respondents

(percentages in brackets)

	District/Area Administrator		DMC/AMC Secretary		GP		GP team members		LMC Secretary*	
No Answer	6	(6.2)	7	(8.75)	11	(8.3)	9	(10.1)	3	(4)
Negotiating Representative	16	(16.6)	19	(23.75)	34	(25.6)	17	(19.1)	18	(22)
Non-Negotiating Representative	35	(36.4)	29	(36.25)	56	(42.1)	33	(37.1)	52	(62)
Type Representative	39	(40.6)	25	(31.25)	26	(19.5)	27	(30.3)	10	(12)
None/DK	-		-		6	(4.5)	3	(3.4)	-	
	96	(100)	80	(100)	133	(100)	89	(100)	83	(100)

Percentages calculated downwards.

District Administrator question 22
District Medical Committee question 25
GP sample question 25
GP team members question 11
Local Medical Committee question: Single District Areas 23,
Multi-District Areas 30.

Table 11.3: Number of GP team members who claimed to have undertaken various activities to seek the views of their colleagues
(percentages in brackets)

	GP Members DMT		GP Members AMT		Total	
Had undertaken activities	63	(84)	9	(64)	72	(81)
Had not undertaken activities	12	(16)	5	(36)	17	(19)
	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team members question 34.

Table 11.4: Methods used by GP team members to seek the views of their colleagues
(percentages in brackets)

Method	GP Member DMT		GP Member AMT		Total	
No Answer	3	(4.0)	-		3	(3.4)
GP Committee Cogwheel	8	(10.7)	-		8	(9.0)
or GP Forums	9	(11.9)	-		9	(10.1)
Local Medical Committee	18	(24.0)	8	(57.1)	26	(29.2)
District Medical Committee	10	(13.3)	-		10	(11.2)
Canvassing, Questionnaires, etc.	7	(9.3)	-		7	(7.9)
Ask Individual GPs	8	(10.7)	1	(7.1)	9	(10.1)
Not Applicable	12	(16)	5	(35.7)	17	(19.1)
	75	(100)	14	(100)	89	(100)

Percentages calculated downwards.

GP team members questions 34,35.

Table 11.5: Frequency with which GP team members sought advice from professional and NHS committees

(percentages in brackets)

	Frequently	Sometimes	Seldom	Never	No Answer/ Not Applicable	Total
Other DMTs	6 (6.7)	27 (30.3)	33 (37.1)	22 (24.7)	1 (1.1)	89 (100)
Area Team of Officers	5 (5.6)	25 (28.1)	22 (24.7)	23 (25.8)	14 (15.7)	89 (100)
FPC Members	3 (3.4)	33 (37.1)	27 (30.3)	26 (29.2)	-	89 (100)
LMC	39 (43.8)	33 (37.1)	13 (14.6)	4 (4.5)	-	89 (100)
Previous GP Team Member	5 (5.6)	17 (191.)	19 (21.3)	28 (31.5)	20 (22.4)	89 (100)
Area Health Authority	3 (3.4)	15 (16.8)	27 (30.3)	44 (49.4)	-	89 (100)
Community Health Council	2 (2.2)	18 (20.2)	23 (25.8)	46 (51.7)	-	89 (100)

Percentages calculated across.

GP team members question 39.

CHAPTER 12

CONCLUSIONS

12.1 Introduction

The conclusions follow the pattern of the hypotheses outlined in chapter 4, part 1. The discussion falls into three headings; the representative system, co-optation in the complex organisation, and co-optation and the 1974 reorganisation of the NHS. It is not intended to be a recapitulation of the content of the thesis but draws upon some of the more important findings discussed above.

12.1.1 GP Participation in the Representative Process

The discussion of representation started from writings in the political science literature and was developed using ideas drawn from role theory. The hypothesis drawn from these theories was that, (c) Constituents act instrumentally and so their commitment to the representative system will depend upon their knowledge of its structure and operation, their evaluation of its past performance and their expectations of its future performance.[1] The assumption of instrumental action was based upon the discussion of dependency within the fragmented occupational groups of a complex organisation and the analysis of the position of the GP within the local health service: his 'gatekeeper' and referral functions as well as his relationship with other groups of employed NHS staff such as nursing and health visiting staff. Therefore it was argued that participation in the representative process for GPs was a recognition of this dependency and demonstrated some belief in the value of instrumental activity in the representative system, its performance, and its future potential.

In section 5.2 it was shown that the involvement of GPs in the professional and advisory committees which make up the representative system was restricted to a small proportion of GPs many of whom belonged to more than

one committee. The majority of respondents did not belong to any such committee and important ideas were given by respondents to explain this non-participation. One group of respondents emphasised the priority of the treatment of patients and 'the partnership' above other activities while another group described such participation as 'medico-political' activity which did not interest them. It was frequently assumed that participation in professional or advisory committees could reasonably be left to the medico-political enthusiasts with apparently very little loss for the practising GP.

Another category of explanations for the non-participation of many GPs in the representative system may be termed structural. These explanations focussed on the position of general practice within the structure of the medical profession, its part in the local NHS, and the impact of independent contractor status with separate FPC administration. Through the GP survey it was clear that a substantial proportion of GPs had only very limited knowledge about the structure of management at the district or area level of the service or within their own locality. Some respondents did not know what a District Management Team was and therefore instrumental action was not possible.

In contrast there was a small proportion of GPs who shared an abnormal pattern of participation and it was from these 'experienced GPs' that the GP team member was often selected. Not surprisingly they showed a wide knowledge of the structure of the representative system and also of the issues currently on the policy-making agenda. This knowledge is particularly important since the management structure is disjointed and there are different levels of authority and different means of medical contribution at each level.

Apart from participation in the representative system through committee membership there were other means by which the constituent could affect the outcome of representation through instrumental action. The most obvious form of action was taking part in the selection of a GP team member.[2] The Grey Book had suggested that the DMC/AMC should select the two clinical team members and therefore many GPs could only indirectly take part through the selection of GP members of the DMC/AMC (DHSS, 1972a). Given the indirect nature of representative selection many GPs understandably felt distanced from the selection of a GP representative. Frequently selection of GP members of the DMC/AMC was a matter of accepting enthusiastic volunteers or persuading less enthusiastic GPs to fill vacancies. Competitive election was very rare.

Another form of instrumental action was through various forms of role-sending through which GPs attempted to influence the views or actions of their representative on the DMT. Less than 30% of the sample of GPs had ever contacted their representative about any matter concerning district management or services.[3] The content of expectations is discussed in section 12.5. This pattern of role sending may be explained by reference to a number of difficulties. These largely result from structural factors mentioned in hypothesis (e) which suggested that both representatives and constituents were subject to structural and environmental factors. There was evidence to show that constituents suffered from poor visibility which prevented them from knowing what items were on the policy-making agenda and therefore made role sending difficult.[4] It also made it difficult to see the consequences of previous expectations and subsequent representative or team action. The proximity to information meant that the GP team member often saw an issue in terms of a wide range of expectations which the ordinary GP did not see. The poor formal relationships in which GPs seldom received minutes or reports from the GP member or the management team inhibited the

informal relationships so that the expectations from ordinary GPs were often limited to complaints or reactions to previously agreed policies.

A feature arising from the different ideologies of GP and management team was that the GP often thought in individualistic terms about particular issues concerning the hospital/community interface while the GP team member was increasingly exposed to the full range of services provided in the district. For instance closure of small cottage hospitals was viewed by GPs as a reduction in service and exclusion of GPs while management teams were concerned with balancing a budget and relieving pressures from AHA or RHA.

The picture of a representative system in which GPs are active participants in professional and advisory committees and in trying to influence their clinical team member does not fit with the survey evidence. The majority of GPs knew little about the representative or management system and received sparse information about the issues under discussion in the local service. There was however an active core of GPs in most districts/areas who played a part in the professional and advisory committees and fitted the picture of the 'active constituent'. It is the activities of this core which are discussed in the following three sections on the DMC/AMC, the LMC, and role expectations in the representative system.

Hypothesis (d) suggested that the outcome of the representative system depended upon the homogeneity or heterogeneity of the constituents in question.[5] Undoubtedly the GPs must be regarded as a homogenous constituency with a single specialty and a shared practice orientation. It may therefore be that an active core of GPs may reasonably represent the views and expectations of GPs in a locality but it seems unlikely that GP team member will be able to ensure that his constituents support the implementation of policies.

12.1.2 The District/Area Medical Committee in the Representative Process

It may be argued that the DMC/AMC was devised to compensate for the low levels of GP activity in the representative system and to co-ordinate the various forms of advice and expectations arising from different specialty groups within the local health service. In Birch's term the DMC/AMC represented a microcosm of the local medical profession with the additional factor of a numerical balance between three different sections: GPs, Hospital Doctors, and Community Doctors (Birch, 1972). The DMC/AMC was to act as a proxy constituency for the whole range of medical opinion and to occupy an intermediate position between specialist groups of practitioners and the management team.

Hypothesis (a) argued that the outcome of the representative system depended upon, among other things, the collective behaviour of constituents bearing in mind the effect of structured factors.[6] It must be recognised that the DMC/AMC constituency includes the full range of the medical profession practising within the district or area. This was clearly the appropriate constituency in view of the objectives of comprehensive, integrated, and rationally produced services espoused in the Grey Book (DHSS, 1972a). It failed to recognise that for many issues this was not the appropriate constituency either in the eyes of the specialist groups of clinicians involved or in terms of the nature of issues to be resolved. The legitimate functions of such a committee were to examine matters concerning the hospital-community interface, to resolve differences of opinion between groups of doctors in different forms of medical practice, and to produce agreed priorities from competing demands for resources or new developments. For issues of specialist advice the appropriate source was the single specialty or hospital committee not the multi-specialty committee.

It was in partial recognition of this that the Hospital Medical Executive Committee or Medical Staff Committee was given direct access to the DMT/AMT in many localities. The failure to clearly distinguish issues of relevance to the whole constituency of the profession from those of interest to one sectional group was an important factor contributing to duplication of function and disillusionment in many districts (Brown, 1979).[7] Additionally the creation of the DMC/AMC took place at a time when the rate of expansion of financial resources was curtailed and therefore, except in those districts with an important capital project such as a new hospital development, the incentive for the whole medical constituency to work together was limited.

The substructure of specialist committees within the district or area was unbalanced and this had the effect of increasing the importance of the DMC/AMC for GPs while decreasing its importance for hospital doctors. Thus hospital doctors had well developed Cogwheel, MEC and MSC systems in many districts and areas through which they could articulate their expectations of the consultant team member and the management team. There was no such consistent system for GPs although in some places the development of GP committees was significant.[8] Therefore the only formal access for GP interests at the DMT level was the DMC. The extreme response to this imbalance was that in a few districts consultants had withdrawn their co-operation from the committee and elsewhere their attendance was poor. The response by the LMC to this situation is discussed in section 12.1.3.

A significant factor in the difficulties of the DMC/AMC in defining its own function was that the development of planning throughout the NHS was slow to develop, largely because the appropriate guidelines were not available until 1976 (see Lee and Mills, 1982; DHSS, 1976). Even then the health district had little input to strategic planning which is perhaps the area in which the full range of medical opinion is most needed.

Evidence concerning the levels of formal communication between professional and advisory committees and the management team suggest an important opportunity for bypassing the DMC/AMC and thereby lessening its importance as a co-ordinating committee. To the extent that specialist committees could inform the DMT/AMT directly of their expectations the DMC/AMC became simply another pressure group whose support was useful but who did not fulfil a unique co-ordinating activity.

Two important features characterising more effective DMC/AMCs appeared to be where the management team as a whole attended meetings and where there was an incentive to participants such as a capital development in hand. Frequently the DMT/AMT would also attend the main hospital advisory committee which could perpetuate the imbalance discussed above.

For its GP members, DMC/AMC membership provided a ready source of information with which the problem of 'poor visibility' referred to above could be overcome. The structure of the DMC/AMC emphasised the importance of decision-making through the equal membership of its three sections. This indicated that the committee should be concerned with resolving matters of conflicting views and priorities since one section could not outvote another. It follows that the means by which the committee agreed upon an appropriate agenda and articulated its views were of considerable importance.

From the survey of DMC/AMC secretaries it was apparent that many DMC/AMCs were largely 'reactive' as their intermediate position might suggest.[9] Agenda items were contributed by the chairman and vice-chairman who were also the clinical team members in most cases. The membership seldom raised issues of their own accord and the committee frequently acted as a 'sounding board' or a 'reference group' for the clinical team members. The GP team members survey showed that, according to the respondents, one DMC/AMC in four had not agreed any policies which they wished the team to implement.

Not surprisingly the DMC/AMC secretaries took a more favourable view. A majority of DMC/AMCs recognised that their distinctive contribution lay in achieving wide ranging medical consensus on particular topics and therefore adopted a rule of consensus similar to that of the corresponding management team. The DMC/AMC secretaries only identified a narrow range of strategies for dealing with conflicts of views or interests.

Structural features were an important influence upon the success of the DMC/AMC and these included the socio-geographic structure of the district/area and the structure of professional and advisory committees. Some districts had major hospitals so positioned that many referrals were made across district boundaries while some were so large that a single DMC/AMC was not feasible. A compact district with a single site for acute services might facilitate the operation of the DMC/AMC since the interests of a wide range of the profession were more closely focussed than where there was a wide range of acute hospital sites and interests were fragmented.

The DMC/AMC provided a formal means of access for GPs for whom there was no widespread representative system directed towards local NHS management. The range of issues for which the views of the whole medical profession were needed and in which there was a widespread interest were limited and therefore the sectional advisory and professional committees were perhaps more important in many localities. This view was supported by the Chief Medical Officer's Working Party which questioned the need for a multi-specialty DMC/AMC and proposed separate advisory committees for the different sections of the profession (DHSS,1981).

12.1.3 The Local Medical Committee in the Representative Process

Hypothesis (b) suggested that the constituents' commitment to the representative process would depend upon the extent to which it was consistent with important elements of their occupational ideology. There is no

doubt that the LMC was very closely associated with clear ideas held by many GPs about the terms and content of their work. The LMC was seen by many GPs as the defender of the rights of the independent contractor GP. It was concerned with all aspects of general practice and the phrase medico-political used by many GPs was apt since it was also concerned with the status of GPs within the profession and acted at both local and national levels. The main distinguishing feature of the LMC was its homogeneity of membership based upon the factor of independent contractor status but mainly concerned with general medical practice.

The structural position of the LMC at the area level resulted in coterminosity with the AHA boundaries and therefore the responsibilities of the AMT but an important difference of boundary with the more numerous health districts. It followed that many LMCs related to more than one DMC and DMT and represented a larger number of GPs with a different range of interests. Consequently LMCs, at least in their formal meetings, concerned themselves with matters of interest to their whole constituency and tended to avoid matters of interest to a single district except where that issue was seen to have wider implications because it indicated a trend to be encouraged or resisted. The range of issues of concern to the LMC was different to those of concern to local management and constituent GPs and therefore concern with district services was only one issue amongst many for the committee. Some LMCs displayed structural adaptation in attempts to relate more closely to the appropriate management team or teams.[10]

The chief means by which the LMC acted as a constituency body for GPs can be characterised as informal. Frequently this involved 'cross-membership' - members of the LMC were also members of the DMC and frequently the GP member of the DMT/AMT also belonged to the LMC. Such informal relationships were more important than the formal exchange of minutes and letters and can be characterised as fitting into professional rather than administrative forms

of organisation since they depend upon collegiality and personal relationships not formally prescribed patterns of action.

The LMC played an important part in the selection of the GP team member in most districts or areas. This ranged from the ratification of the DMC/AMC choice in a few districts/areas to the nomination and persuasion of one of their number to undertake a role which was demanding and for which there were often few volunteers. The belief was widely held by LMC secretaries that the GP team member should belong to the LMC and in some cases they were swiftly co-opted upon appointment. Both the GP team members and the DMC/AMC GPs often came from among the past or present LMC membership since LMC service was frequently interpreted as interest and appropriate experience for selection as GP representative and often the 'pool' of suitably qualified candidates for such posts was shallow.

Concern with the activities of management teams and GP team members was a new area of interest for the long-established LMCs and in some cases it took time to recognise the potential of full membership of the management team. A significant proportion of LMCs relating to more than one DMT set up a sub-committee structure of GPs within that district to advise the team member and also the LMC. The membership of these teams usually comprised the elected members of the LMC from that particular district. The legitimacy of the full LMC was accepted unquestionably due largely to a long established electoral system with recognised constituencies. The authority of the district sub-committee was to some extent derived since its members were appointed for a separate, but related, purpose.

Nonetheless the district sub-committee of the LMC formed a 'reference group' for the GP team member and demonstrated the increasing interest of the LMC in local management. Since the constituency of GPs was such that it was difficult for the GP team member to ascertain the views of his

'colleagues' except by inflexible means such as canvassing or by intuition the LMC district sub-committee was an important development in some districts.

Within the representative system the LMC was important since it contained the 'active core' of GPs in many instances. The LMC was not ideally suited to the task of representing GPs' views at the district since its range of concerns was much wider and its structural location was above district level. It could not be said to fulfil a parallel function to the MEC for hospital doctors which was concerned with a limited range of services within the district. However, the committee was highly regarded by GPs and therefore its voice was accepted by GPs and gave the GP team member a strong indication of GP opinion. The LMC was also able to act at other levels within the service and the concentration of functions within one committee was a source of strength. For the DMT/AMT the LMC provided a barometer of GP opinion but did not necessarily mean that a district's GPs would therefore support decisions made on the basis of that advice.

12.1.4 Role Expectations and the Representative Process

Hypothesis (c) suggested that constituents would act instrumentally and that this action would depend on their knowledge of the representative system and their expectations of the likelihood of a desirable outcome.[11] One of the specific forms of such action is the 'sending' of role expectations discussed in section 8.5. Two main sorts of expectations were identified based on the degree of specificity, namely generalised or particular expectations.

The BIOSS typology of representative roles was adopted in which the chief distinction between representative categories concerned the transfer of authority from the constituent or constituency group to the representa-

tive.[12] Judgements concerning the extent of autonomy of the GP team member varied between the different respondents. The sample of GPs found it difficult to distinguish between the options since they had a low level of knowledge about the structure of the representative system and its activity. However three-quarters of the respondents excluded the view of the negotiating representative with considerable authority to commit his constituents to a course of action. The LMC and DMC/AMC secretaries favoured the non-negotiating representative or spokesman option which emphasised the importance of the relevant committee in discussing views and agreeing on appropriate policies. In contrast the sample of Administrators favoured the type-representative.[13] This finding suggests that they recognised that GP team members could not claim to speak on behalf of their constituents or the appropriate representative committees whether LMC or DMC/AMCs. Nevertheless the sample valued having a GP team member who could advise on the implications of proposals for general practice and the possible reactions from general practitioners.

Thus the four groups of GPs, LMC secretaries, DMC secretaries and administrators each had distinctive expectations of the behaviour of the GP team member and the extent of autonomy appropriate for a professional member of a corporate executive.

Two categories can be identified amongst the particular expectations to which the GP team members were subject; expectations from constituents and expectations from members of the management team which frequently concerned the patterns of team activity and the contribution to team business and decision-making. It was noted in section 5.2 that the majority of GPs took no part in the representative process and that participation in representative committees and role-sending was restricted to a small active core. The concentration of interest in the representative system meant that the small proportion of interested GPs frequently had a number of

opportunities through the LMC and DMC/AMC to consult or attempt to influence their representative concerning important issues. However the DMC/AMC and the LMC met relatively infrequently compared with the DMT/AMT and the volume of team business inevitably meant that the GP team member exercised a great deal of autonomy by default since the representative system could not possibly produce clear expectations on any but the most important issues.

Consequently the GP team member needed to seek advice from a range of individuals or committees to discover what were the 'expectations' of those he represented. The pattern of GP interests was such that on many issues the constituents had no clear or strongly held view and therefore the representative had autonomy by default since there was only limited interest in the issue. However a few issues were discovered where the view of GPs was sufficiently strong that the GP team member had no choice but follow those wishes or resign. Such issues were characterised by the actual or threatened withdrawal of services used by GPs or of access by GPs to NHS facilities. Frequently such issues only directly affected a small proportion of GPs in a district or area and therefore there was no concerted GP view. There were very few cases where a wide range of GP expectations favoured a new development or pattern of services except where a new hospital was felt to be necessary.

The pattern of particular expectations held by members of the management team of the GP member was characterised by the feature of marginality.[14] Co-operation from GPs was seldom as important as co-operation from hospital doctors. In particular cases the GP team member was expected to negotiate with GP practices over questions of premises and health centres. As a representative of the DMT/AMT the GP team member depended upon personal charisma and professional notions of collegiality to exercise his persuasive skills.

Apart from issues of special importance, constituents seldom sent consistent expectations to the GP team member and particular expectations needed to be clarified with the LMC or DMC/AMC which contained the active core of GPs within the district. Such discrete expectations seldom placed any great pressure upon the GP team member. However on important issues, expectations would be endorsed by the LMC and where appropriate also by the DMC/AMC. In such cases the GP team member could be placed under considerable pressure or role strain if the DMT/AMT were not amenable to the expectation. It is the role of GP team member as representative which is discussed in the next section.

12.1.5 The GP Team Member as Representative

Discussion of the role of the GP team member must start by emphasising the fact that the team member's primary commitment is to medical practice and the partnership, not to team membership and its associated activities. Indeed the role was envisaged as taking one or two sessions per week only but the findings of this survey suggest a very substantial commitment which is not likely to shrink with the April 1982 reorganisation, the creation of District Health Authorities, and the advent of unit management.

Hypothesis (f) suggested that, the representative's position, as a member of the profession and an equal member of the management team, makes him a focus for competing expectations which arise from a clash of two principles resulting in the necessity for co-optation and representation systems. He is therefore subject to competing expectations and may experience role-strain.[15]

The GP team member was described as the focal person subject to a range of competing expectations or influence attempts. It was argued that these expectations come from two categories of sources namely constituents or constituent committees, and members of the management team. It is not

argued that the action of the GP team member is the sum of the expectations from the full range of sources and that those expectations backed by various forms of power are inevitably successful while other expectations with no such resources tend to fail. Nonetheless the GP team member operates in the centre of a range of expectations of which he must take account.

The expectations came from a number of sources and four have been selected in this study: GPs, DMC/AMC, LMC and Administrators, and they varied according to a number of characteristics discussed in section 4.2.3. Additionally expectations varied in the level of clarity and in the extent to which they were based on appropriate information and expertise. The GP team members therefore undertook various forms of action to clarify the expectations of their constituents or more frequently of the important constituent bodies, the LMC and the DMC/AMC. The main forms of consultation are informal and these include consulting the LMC for advice or raising an issue on the DMC/AMC agenda. A small range of issues may require consultation with all GPs within a district, usually undertaken through some form of canvassing. This is particularly important if it is proposed to alter some service which GPs regard as important. Such issues frequently concerned the rights of GPs in direct access to diagnostic facilities or hospital beds, or the employment of GPs on a sessional basis within the hospital service. In such cases the process of consultation may appear more like negotiation in which the GP team member attempts to come to an agreement with particular GPs in the district. Such issues are relatively rare and few GP team members could give examples of trying to persuade their fellow GPs to accept a particular proposal or policy.

As hypothesis (f) suggested,the GP team member is potentially in an exposed position since he risks losing the confidence of his colleagues if he is closely identified with 'the administration' or management.[16] He may therefore undertake consultation as a means of relieving the pressure

he faces from competing expectations. For instance, obtaining the view of the DMC/AMC or the LMC on a contentious issue may enable the sharing of personal responsibility. It involves the risk that the body consulted may come to a different view than the representative or the team and there is also the risk that the committee will come to no decision or defer the issue with similar consequences. One means of dealing with such a problem was where the DMT/AMT collectively presented contentious issues to the DMC/AMC in a formal meeting. However the GP clinical member still risked losing credibility by being identified with the DMT/AMT not with his fellow GPs.

It was clear from the study that in many districts the DMT/AMT had not dealt with any issues with which GPs were seriously concerned. The concentration of government priorities on the elderly, the mentally handicapped and the maternity services meant that in some localities services with which GPs were most concerned had received attention during the period preceding the study. Many of the GP expectations recognised gaps in the acute services which were shared by the hospital doctors and there was therefore no difference of interest.

The GP clinical members were also subject to a range of expectations from within the management team. The first category can be termed structural since they were built into the pattern of working of the team. Evidence showed that meetings were long, frequent and intensive and GP team members needed to undertake a considerable amount of work in preparation for formal meetings. It was also clear that GP team members needed to learn a great deal about NHS management and a range of skills to facilitate team working. A number of management teams operated a rotation system for the selection of a chairman and this was a particularly arduous role for the GP member even though the Administrator retained a co-ordinating responsibility.

Many DMT/AMTs recognised that team membership was a secondary activity for the GP member and therefore did not expect him to produce formal papers on issues presented to the team. Nonetheless recognition of an appropriate role for the GP team member required that the team collectively assess the unique aspects of his contribution to the team. While it was clear in the Grey Book that the GP team member's contribution was essentially different to that of the functional managers, there was evidence that the GP team member tended to become a marginal member of the team in a way different to that of the consultant member (DHSS, 1972a).[17]

The DMT/AMT was expected to operate according to the role of consensus and therefore each member had an implicit veto on team decisions. The implication of the use of a veto was that the decision reverted to the Area Health Authority for consideration. This strategy was used as a political manoeuvre but only very infrequently and therefore there were expectations that the team would arrive at consensus decisions even if these were only minimally acceptable (Schein, 1969). Undoubtedly the DMT/AMT with its regular meetings exposed the GP team member to a wide range of expectations since there was a high degree of inter-dependency between members and interaction was face-to-face making expectations and their implications clear.

Team membership for the GP represented a considerable commitment in time and effort. Experienced GP team members had a wide range of knowledge about the local management and planning of health services which distinguished them from their colleagues. Such experience inevitably affected their view of issues and for some members the Grey Book description of their role as 'a full member of the management team' was accurate.

12.2 Co-optation in the Complex Organisation

The study was confined to one aspect of co-optation within the NHS since the medical profession was co-opted to several different levels of management in the 1974 reorganisation reflecting the disjointed management structure. It follows that the participation of the GP team member on the DMT/AMT is only one of the ways in which the designers of the reorganisation attempted to overcome the difficulty of two different principles of work within a complex organisation.

Hypothesis (a) asserted that organisations could avert threats to their stability by co-opting threatening groups.[18] The nature of the threat was that the presence of autonomous professional groups within a complex organisation prevented the policy makers from ensuring that their policies were implemented by the professional staff. Clearly there were negative controls which could be imposed to prevent overspending or excessive use of particular resources but it was more difficult to ensure support for policies and positive action.

Hypothesis (b) suggested that the outcome of a co-optation strategy depended upon the form of co-optation undertaken, the nature of the complex organisation and its constituent occupational groups, and the effects of environmental and structural influences.[19] The two sections of the profession which provided services to individual patients were co-opted to the management team since clinical autonomy justified unmanaged status (Tolliday, 1978). Community Medicine was 'represented' by an officer and treated in the same way as a non-medical function. The selection of GP and consultant showed the importance given to the practice orientation - general practice and hospital practice respectively - and also the existing patterns of organisation of the two sections of the profession. While the consultant team member represented a wide range of separate specialties

there were also a corresponding range of professional committees fulfilling a co-ordinating role. The GP team member represented one specialty with a single practice orientation but a particular form of autonomy summed up in the concept of the independent contractor. The GP occupied a central position in the production and distribution of health services as 'gatekeeper ' to the full range of secondary health services. Additionally the GP dealt with the majority of patients personally without any need of hospital or specialist services.

Thus the clinical specialties were co-opted onto the local management team since they were the source of effective demand for the full range of services and the sum of their individual decisions largely directed the activity of the organisation. External factors affected the need to co-opt the medical profession - a process which had taken place in some form since the beginning of the service - including political judgements concerning the cost of the service, the patterns of need, and desirable future policies.[20]

Hypothesis (c) suggested that the form of co-optation strategy adopted would depend upon the extent to which the leadership felt its objectives were threatened by professional groups and also by the precise nature of that threat.[21]

The threat to the objectives of the NHS posed by an autonomous profession was exacerbated by the advanced specialisation and fragmentation of the medical profession based upon differences in the content of work and the terms of work. Development of intra-professional groups was described in section 1.2 and involves the identification of special areas of expertise and the attainment of limited autonomy within a largely autonomous profession. Specialisation resulted in the development of intra-professional groups with distinctive content or work and also a dependency between groups since the division of labour was such that most patients receiving

secondary care services require the services of more than one specialty and there are patterns of relationships between those specialties which treat patients and those which provide diagnostic and other services. Similarly there are clearly recognised, unwritten 'rules' concerning the relationship between GPs and hospital consultants and these cover such issues as the responsibility for patient care and its transfer.

Consequently the form of co-optation adopted resembled Selznick's category of 'formal co-optation' with the co-optation of clinical representatives to the DMT/AMT and medically qualified members to the health authorities (Selznick, 1949). How then, has the formal co-optation fared regarding Selznick's prediction of 'tokenism'? Firstly, the DMT/AMT have negative powers with which they can prevent some forms of action by clinicians since the budgets for most clinical services are held by administrators although spending decisions are made by doctors. These negative powers do not exist with respect to GPs since their budgets for prescribing are 'open-ended' and they also have freedom to refer patients to the consultant of their choice.

Within the NHS policy objectives are decided at a number of different levels and the individual policies at each level are not always consistent. The Minister of Health sets broad priorities, obtains financial resources, and may make important policy decisions in the last instance. Strategic policies are made at the Regional level and districts (and areas before 1982) are responsible for the strategic and operational decisions. It follows that the leadership is disjointed and the DMT/AMT is only a corporate executive as far as local services are concerned. The teams' decisions are dependant upon policy decided at other levels and may be overturned by these levels. It follows that many issues require the participation of more than one level of authority before a decision can be made. For instance, consultant contracts are held at the Regional level and there-

fore a district cannot appoint a new consultant without obtaining the agreement of the Regional Health Authority. Likewise since GPs contract to provide services to the FPC changes in the pattern of services which they offer may require FPC agreement.

Therefore the leadership of the NHS is disjointed and co-optation takes place at a number of levels of authority within the service. Since the DMT/AMT is largely concerned with the operational management of services and these services are provided by, or under the direction of, autonomous clinical doctors the co-optation strategy is a particularly important means by which the leadership has attempted to increase the probability of implementation of its policies.

Hypothesis (d) argued that, Co-optation of powerful professional groups onto the corporate leadership may result in the sharing of policy making but persisting failure to ensure implementation due to the nature of authority in professional groups.[22] Undoubtedly co-optation of the GP team member on to the DMT/AMT has given a voice to GPs concerning the development and management of the services for which the team is responsible. It was shown in chapter 9 that the GP team member role is difficult and demanding since it is necessarily a secondary activity for the GP and takes place in an environment characterised by administrative patterns of organisation, albeit with the safeguard to the professional members of consensus. The extent to which the GP team member is able to overcome the structurally induced tendency towards marginality depends upon his personal characteristics and also the extent to which the team recognise the value of his contribution and assist him to participate in decision-making.

The process of representation was seen to depend very much upon the structure of authority within the specialty of general practice and the

representative structures which are ideologically acceptable to GPs. Clearly the range of GPs' interests extends beyond considerations of the district or area although DMT/AMT actions may affect the workload and the pattern of work and opportunities open to GPs. There was evidence that many LMCs were increasing their interest in the activities of local management and various adaptations took place to facilitate this interest.[23]

Perhaps the most important finding from the discussion of the representative system was that the GP team member was not able to emulate the role of the functional members of the management team, namely the officer members, who took their place as heads of hierarchically ordered occupational groups. The GP could not commit his colleagues to a course of action agreed by the DMT/AMT since the link with GPs through the representative system was uncertain. Some districts claimed that the consultant member was elected by every consultant in the district and was supported by a comprehensive advisory system through which consultants could articulate a collective view. This was not the case with respect to GP representation. The role of the GP team member depended not upon a recognised representative system through which GPs transferred authority to a representative to act but rather upon the abilities and skills of the GP team member who needed a shrewd insight to distinguish between those matters in which there would be no opposition from GPs and those matters which he could not support.

Implementation of agreed policies by GPs was difficult to discern since most policies concerned activities managed by the DMT/AMT or provided through the hospital and community health services. Where there was a shared project concerning development of a new service or facility GP interest was often more evident and the DMT/AMT played a significant role in agreeing policies and details of provision. Co-optation of GPs may have improved the quality of DMT/AMT management, due largely to the personal qualities and endeavour of GP team members but the likelihood of implemen-

tation of policies and their support by GPs only increased to the extent that policies were perceived by GPs as self-evidently good or appropriate.

12.3 Co-optation and the 1974 Reorganisation of the NHS

Hypothesis (a) suggested that, the outcome of the co-optation process will affect the policy goal of integration of service planning and delivery at the local level.[24] Undoubtedly the co-optation of a GP team member and the equal representation of GPs on the DMC/AMC provided an opportunity for GP participation at the local level which had not been previously possible. The exclusion of independent contractor services from the direct responsibility of the AHA and the management teams meant that general practice continued relatively untroubled by the considerable upheavals in the hospital and community services in the mid-seventies. Participation of GPs in the DMC/AMC and membership of the DMT/AMT appeared to be undertaken by an 'active core' of GPs frequently drawn from among the LMC membership who displayed abnormal levels of committee membership and interest. The majority of GPs surveyed showed low levels of knowledge and interest in the representative system and apart from taking part in the selection of representatives to the DMC/AMC, most took no active part in the representative system.

The goal of integrated service planning and delivery was hindered by factors apart from failure in the representative system underlying the co-optation of GP team members. Most important was the serious delay in the publication of the formal planning system which delayed any concerted attempts at integrated planning until two years after the reorganisation. The separation of strategic and operational planning also affected the development of integrated planning.

Hypothesis (b) suggested that, to determine and implement policies the leadership will either have to find a means of achieving agreed policies

or a source of authority by which they can ensure that the policy is implemented by those who do not share its goals.[25]

The DMT/AMT with its membership of clinical representatives and heads of hierarchically organised occupational groups provided a forum at which policies could be agreed which were acceptable to all members although resolving contentious issues took a large amount of skill from team members. The GP team member, who was primarily a practicing GP, had a large amount to learn about district/area management before he could act as a full member of the management team. There was a serious danger that he could become a marginal team member and simply speak as a typical GP or 'type representative'. Undoubtedly team membership and exposure to the expectations and information associated with the role meant that an experienced GP team member often ceased to resemble a typical GP in any objective sense, but displayed views of a corporate manager, recognising the complexities of team management.

The representative system was such that the GP team member could not, in most cases, speak for his fellow GPs with any degree of certainty since the representative structure only involved a minority of GPs who were in many respects untypical of their colleagues. However the homogeneity of general practice meant that GPs had a narrower range of interests than those of the consultants whose specialty or intra-professional group interests differed from that of their colleagues.

There were few instances of integrative plans which required the support of GPs within the district for their support. Some examples were found where GPs were asked to alter their patterns of referral or their requests for diagnostic tests. Even these examples caused difficulty since GPs had varying patterns of referral and used different tests and therefore demonstrated degrees of heterogeneity in certain respects.

Additionally such policies might be seen to involve a question of restriction of GPs' clinical freedom and therefore have wider implications. Issues of this sort would often be referred to the LMC who claimed the legitimacy to speak on behalf of GPs especially in defending their interests. There was certainly no means by which the DMT/AMT could ensure that GPs followed policies whose goals they did not share except by the use of negative administrative powers through controlling budgets of hospital and community services and similar means.

Hypothesis (c) suggested that, co-optation at the local level would enable policy-makers to take account of local needs which are assumed to differ from those of other localities.[26]

Maximum delegation of authority to the local level was one of the formal objectives of the 1974 reorganisation and the co-optation of GPs was expected to ensure that services were responsive to need. While epidemiological conceptions of need were part of the role of the community physician the GP acts as the 'gatekeeper' and effectively translates a patient's reported symptoms into an effective demand for services. By acting as a proxy consumer the GP is aware of the range of demands made upon the service by patients and also the extent to which those demands are met satisfactorily. This knowledge is not systematic in its evaluation of locally provided health services but covers a wide range of the services provided and the GP is often aware of the views of patients concerning the services they have received.

The GP team member survey showed that many GPs expressed concern with deficiencies in local services such as long waiting lists, inadequate provision of particular specialist services or poor and inefficient organisation of services.[27] In many cases these criticisms implied expansion of services, creation of new consultant posts, or development of existing

institutional services. There were however a significant number of GPs who were concerned with the development of community health services particularly through the creation of new posts for community nursing and paramedical staff. These needs were certainly different to the needs of neighbouring districts which had inherited a different collection of institutions, specialist posts, and community services. While many neighbouring districts had shared problems in particular services such as psychiatric inpatient and mental handicap services related to the pattern of large hospitals serving more than one district, co-optation of the GP team member allowed the expression of local needs particularly in acute and community services which were provided within the district and particular to that district. While such factors were brought before the management team by the GP team member, there were many difficulties before improvements could be undertaken and therefore it can be argued that the policy-makers were made aware of deficiencies in services but not necessarily responsive, at least in the short term.

Hypothesis (d) suggested that, disjointed policy-making structures in the NHS act against the success of co-optation mechanisms in achieving integrated leadership at the local level.[28]

One of the main objectives of the 1974 Reorganisation of the NHS was to achieve effective central control over an ultra-complex organisation. Consequently there was a standard pattern of delegation of authority, in accordance with administrative principles, from the Minister who was accountable to Parliament, to the DHSS, Regional, Area and District levels of authority. It follows that the authority of the DMT/AMT was limited by policies of the AHA and RHA. Additionally there were standard procedures relating to many of the capital and manpower developments required at the local level. In some districts there was a considerable degree of day-to-day autonomy because of the structural location of the AHA and its

simultaneous relationship with other districts. However a consequence of this was that decisions requiring AHA or RHA approval might be very slow to obtain. The parallel organisation of independent contractor services may have been inevitable but was certainly unhelpful since it did not facilitate central control and good management to any extent nor did it help responsiveness and local integration of services.

Co-optation of a representative GP onto the DMT/AMT was one step towards improving the quality of management at the local level. It needed to overcome a wide range of problems resulting from the administrative structure of the NHS, the structure of the medical profession and its component intra-professional groups, and the occupational ideology of GPs related to the appropriate content and terms of work. Co-optation could not solve these problems alone but represented a step in the right direction.

Notes

Chapter 1

1. Both Etzioni (1961) and Rowbottom (1973, 1977) have written about 'complex organisations'. The complexity arises from the task of the organisation or the range of demands it fulfils. Such organisations have an advanced division of labour and particular groups of workers exhibit particular occupational ideologies and patterns of work. Management of such an organisation is, understandably, complex.

2. The functional category of systems' maintenance was first discussed by Parsons (1953). The model consisted of four functions and formed the basis of his theory of action. This is discussed by Rocher (1974).

3. See section 1.6.

4. A similar point is made by Johnson and discussed on page 5.

5. The multiple triangulation approach is also employed in the empirical study, chapters 4-11, which attempt to combine a variety of methods to confirm the findings.

6. Structuralism is a method of social explanation which focusses on material factors as the chief means of accounting for social behaviour, in this case the behaviour of the occupational group. This is discussed in Wallace (1969), pages 24-34.

7. It is not argued that professions do not benefit society but that such benefits cannot be taken for granted. Illich has eloquently stated the counter-argument. (Illich, 1977).

8. See page 9.

9. There are a range of conditions, often at the margins of medical care where the success of treatments is not established, where it is argued that social or holistic models of care are more appropriate.

10. The content of work is inevitably constrained by the available resources and the means of distribution of those resources. For instance, the 'fee for service' system may encourage the use of various procedures and discourage the use of others.

11. The term 'practice orientation' is used to refer to the terms of work and particularly the relationship with other practitioners. In this study independant or family practice, hospital practice and community practice form the most important practice orientations.

12. External factors may affect the autonomy of intra-professional groups such as changes in the pattern of demand. The decline in tuberculosis due to environmental factors has affected the specialty structure of hospital medicine.

13. Different medical specialties may offer different treatments for similar conditions where there is no clearly successful remedy. These may demonstrate claims for autonomy in a particular area.

14. See Lee and Mills (1982) chapter 9 and also Haywood and Alaszewski (1980).

15. Use of the term bureaucracy may suggest professional-bureaucratic conflict theory which only emphasises one aspect of conflicting interests. See Allrow (1970), page 13 and chapter 5.

16. This is similar to Ritzer's view of professionalism discussed on page 6.

17. See section 1.4.

18. See also Butler (1970) for discussion of the sick role.

19. See page 8.

20. These studies showed that workers used informal systems of ideas with symbolic punishments to control the speed of work in the interests of the work-group.

21. The medical specialty of community medicine is organised hierarchically to some extent as are specialties such as pathology which are often structured in an administrative pattern.

22. These concepts are discussed in Hunter (1980) chapter 3.

23. This is referred to as 'tokenism' elsewhere in the thesis since the token representative has no real power.

24. Consultation may produce real changes and be an important aspect of co-optation but it has the popular reputation of being largely formal and ritualistic.

Chapter 2

1. The hypotheses arising from the discussion of the process of representation are discussed in section 4.1.1 and those concerning the function of representation in 4.1.2 and 4.1.3.

2. It follows that the analysis must examine the precise nature of specialisation within the profession and its consequences for the structure and pattern of intra-professional groups.

3. These discussions are chiefly focussed upon the importance of representation in the representative democracy. Pitkin (1967) has written more expansively and places less emphasis on formal conceptions of representation.

4. See Zetterberg (1965) chapter 3.

5. The use of the term constituent follows logically from the context of these writings, namely representative/democracy. It is used throughout the thesis to denote those who are formally represented by the representative in question. It does not imply that the representative or the representative process is effective.

6. Dibble suggested a parallel argument in the distinction between parochial or ecumenic ideas and their significance amongst homogenous or heteronomous audiences. See page 19f.

7. Her approach differs from the formal theories of Birch (1972), Riemer (1967) and Eaulau (1959, 1969) and identifies a more fruitful way of adapting work from political science to a different context.

8. See page 25.

9. See page 20.

10. See page 17.

11. Birch's analysis may be seen as a development of Apter's typology since the three main categories identified by Birch are almost identical to those developed by Apter.

12. These mechanisms are likely to be intermediate representative committees of constituents referred to below as representative bodies or proxy constituencies.

13. In the complex organisation simple monocratic models are unlikely to be satisfactory although various rationalising strategies may be used. See page 22.

14. See Schein, 1969.

15. See page 43.

16. The importance of information as a source of power was discussed on page 38.

Chapter 3

1. The Medical Officer of Health was a chief officer of the Local Government Authority responsible to an elected council, not part of the NHS.

2. The circular entitled 'Structure and Management' HC(80)8 emphasises the importance of management at the local level with lay participation through new District Health Authorities and medical and nursing participation through the unit management groups.

3. See section 1.4.

4. Since a medical administrator was unacceptable a powerful administrator was important to co-ordinate the non-medical functions in the hospital.

5. This is usually referred to as the Porrit Report after the Chairman.

6. The importance lay not in the number of new hospitals built but in the concept of a full range of services provided within the district which it implied.

7. See section 2.4

8. See DHSS 1972a.

9. See section 2.4.

10. A 'political' or pluralist approach has been evident in some recent work on the NHS including Haywood and Alaszewski (1980) and Hunter (1980).

11. See Patients First (DHSS 1979).

12. By leadership is meant the most appropriate position for an individual to 'manage' or co-ordinate separate functions of the NHS.

13. The term collective chief executive does not imply that doctors are managed by the team but rather that the team has a co-ordinating function and members are responsible for managing, or representing, their own functions.

14. Representation of clinical views may be much easier in a geographically compact district than in a widespread district with a range of hospitals and other facilities.

Chapter 4

1. See section 1.6

2. Chapter 5 contains an overview of the process of representation and chapters 6-11 examine the component parts of the representative process in more detail. Chapter 12 reviews the hypotheses in conclusion.

3. The possibility of inconsistency between ideology and action was remarked upon above. See page 5.

4. See page 229f.

5. See section 5.2.

6. See section 8.3.

7. See page 19.

8. See pages 39-40.

9. See section 11.3.

10. See pages 44-45.

11. The objectives of the 1974 reorganisation of the NHS are discussed in section 3.5.

12. Methods of conflict resolution are discussed in relation to the DMC/AMC (pages 158-162), the LMC (pages 186-187) and the DMT/AMT (pages 261-264).

13. See chapter 6.

14. See chapter 9.

15. These reports include Plouviez (1971), Fawcett and Loder (1973), Howat (1973) and Pethybridge (1976).

16. See sections 3.2 and 3.3.

17. See section 3.5.

18. The samples of GP team members and GPs were also able to answer questions concerning the DMC/AMC from different perspectives enabling a comparison of responses.

19. The importance of information was discussed in the context of visibility in the representative process (pages 36-37) and power in the representative process (pages 38-39).

20. See page 68f.

21. See Patients First (DHSS 1979).

22. Medical Directory (1979).

23. The doctor's age had to be estimated since the Medical Directory did not include it. Sufficient details were included about training and date of qualification to allow a reasonable estimate.

24. See Denzin (1970).

Chapter 5

1. These methods frequently have implications for efficient medical practice such as ensuring target populations receive appropriate services, immunizations or screening procedures but they also affect the practice income.

2. The size of the remuneration for clinical members of the management team was a matter of concern to the British Medical Association who conducted a study to support claims for higher levels of remuneration (BMA 1977).

3. See page 79.

4. See Appendix.

5. This does not sufficiently emphasise the difference in boundaries between many LMCs and the appropriate health districts. In contrast the MEC or MSC is within the appropriate district.

6. A substantial proportion of GP team members had served for 5½ years in an arduous extra duty at the time of the survey.

7. See page 295. The DMC/AMC secretary sample did not highlight those DMC/AMCs which had fallen into disuse since those districts fell into the category of non-respondents.

8. See page 30f.

9. See pages 52-53.

10. Since each survey was independent the number of inactive DMC/AMCs varies between the four samples. See page 102.

11. See pages 229-232.

12. The role of the DMC/AMC was to go beyond the agendas identified for advisory committees within the hospital service. See page 51f.

13. Commentators such as Haywood and Alaszewski (1980), Hunter (1980) and Brown (1979) have been more concerned with the processes by which the NHS operates and the effects of the distribution of power among participants than with formal models of the organisation and relationships between its component parts.

14. See page 132.

15. See page 167f.

16. The GP team member showed a very different pattern of behaviour from the sample of GPs. Table 5.29 shows the frequency that GP team members raised issues at DMCs and AMCs respectively.

Chapter 6

1. Monitoring is a necessary activity if co-ordination is to take place.

2. See table 9.4.

3. See page 120f.

4. Table 5.29 suggests that the GP team members raised issues at the DMC/AMC for discussion relatively frequently.

5. See page 236.

6. See March (1958).

7. These categories are used in a shortened form in table 6.4 and throughout the thesis.

8. See page 157.

9. See page 153.

10. See pages 36-37.

11. See page 34.

12. See table 5.8.

Chapter 7

1. Medically qualified LMC secretaries included GPs (55%), retired GPs (1%), retired DHSS RMOs (4%), and medically qualified full-time LMC secretaries (13%).

2. It appeared that the agendas for LMCs serviced by the London secretariat were largely the responsibility of the three medically qualified secretaries.

3. It was noted in table 5.6 that 71% of GP members of AMTs were also members of the FPC.

4. The LMC does not make policy in the same sense as an executive body since it does not have administrative authority with which to ensure implementation. It does however come to agreements and may attempt to persuade GPs to support them.

5. See Royal Commission (1978) paragraph 8.14.

6. See section 7.5.

7. In some LMCs the role of this committee was best described as that of a 'watchdog' committee.

Chapter 8

1. See section 5.2.

2. See page 123f.

3. See page 36f.

4. See page 40-41.

5. This demonstrates the importance of the ideas of delegate and representative amongst the sample of GPs. See section 1.4.

6. Similar views were expressed by GPs who focussed their criticism on administrative inefficiency. See page 288.

7. See page 216.

8. See table 8.6

9. Many of the GPs had been contacted for more than one purpose and so the responses do not total 36 GPs.

Chapter 9

1. In some cases the GP AMT member regularly attended meetings of the AHA but this was not the common pattern. Most attended only for items of special interest.

2. See page 116f.

3. The use of diary analysis was considered as the last question on the GP team member survey shows. It was rejected since the study suggested that the levels of interaction would not be demonstrated by such a method.

4. See Eskin 1979.

5. Since there was no survey of consultant members one aspect of this interaction was not available.

6. See Page (1981).

7. Since the 1982 reorganisation and the removal of an intermediate, area level of authority the importance of strategic planning at district level has increased.

8. See page 217.

9. DHSS (1972)

Chapter 10

1. It may be that HCPT minutes were received by the community physician and that routine planning was seen as part of his function.

2. See page 133.

3. See section 9.3.

4. Table 10.9 shows very similar responses between district and area administrators.

5. The corresponding finding from the GP survey is shown in table 8.3.

6. See page 90.

Chapter 11

1. See DHSS (1981) and HC(82)1.

2. See section 8.3.

3. See Hunter (1980).

4. A further three GP team members did not answer the question suggesting that they felt such activities irrelevant or unimportant.

5. These were questions 11, 12, 14 and 15.

6. The questions were designed with zero-sum implications to prevent unrealistically optimistic views being expressed.

7. This resentment concerned the social worker's position in rationing a scarce resource.

8. See page 298f.

Chapter 12

1. See page 81.

2. See page 122f.

3. See page 216f.

4. See section 8.3.

5. See page 82.

6. See page 79.

7. A number of respondents reported that the DMC/AMC had ceased to function effectively. See page 295.

8. The LMC had important informal relationships with many DMC/AMCs and management teams through cross-membership and membership of the GP team member. See page 190.

9. See section 6.2.

10. See section 7.5.

11. See page 81.

12. See page 213f.

13. See pages 281-2.

14. See section 9.3.

15. See page 83.

16. See page 83.

17. See page 235.

18. See page 85.

19. See page 85.

20. These political judgements were discussed with the main decisions upon which reorganisation was based. See section 3.3.

21. See page 86.

22. See page 87.

23. See pages 187-8.

24. See page 88.

25. See page 89.

26. See page 90.

27. See section 11.4.

28. See page 90.

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A

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer by ticking the appropriate box or boxes. Where there is no box provided please write your answer in the space below the question. If you work in a single district area please read "Area" where district is mentioned in the questionnaire i.e. Area Management Team and Area Medical Committee. There is room for any additional comments at the end of the questionnaire.

To be answered by the G.P. member of the District Management Team.

1. How many partners are there in your practice including yourself?

one	☐
two	☐
three	☐
four or more	☐

2. Are you currently a member or have you ever been a member of any one of the following committees or groups?

	currently a member	have been a member
Family Practitioner Committee	☐	☐
Local Medical Committee	☐	☐
Health Care Planning Team	☐	☐
Community Cogwheel Division	☐	☐

Questions 3 to 11 are about your membership of the District Medical Committee

3. When did you become a member of the District Medical Committee?

1974	☐
1975	☐
1976	☐
1977	☐
1978	☐
1979	☐

4. Which of the following positions do you hold on the District Medical Committee?

chairman	☐
vice-chairman	☐
ordinary member	☐

5. How are the chairman and vice-chairman of the District Medical Committee selected?

elected by District Medical Committee members	☐
they take their turn by rotation	☐
another method (please specify)	☐

6. Do you feel that the District Medical Committee has agreed on any particular issues that it wishes the District Management Team to pursue?

Yes	☐	please go to question 7
No	☐	Please go to question 8

7. What are the main issues that the District Medical Committee wishes the District Management Team to pursue?

8. How often do you write reports of District Management Team activity for the District Medical Committee?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

9. How often do you talk about the District Management Team's activity at District Medical Committee meetings?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

10. Have you ever tried to persuade the District Medical Committee to change its mind on a matter for which there was strong District Management Team support?

Yes	☐
No	☐

11. How often do you raise items at the District Medical Committee meeting on behalf of the District Management Team?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

Questions 12 to 37 are about your membership of the District Management Team.

12. When did you become a member of the District Management Team?

1974	☐
1975	☐
1976	☐
1977	☐
1978	☐
1979	☐

13. For how long is your appointment as a member of the District Management Team?

for one year or less	☐
for between one and two years	☐
for two or more years	☐
for an unspecified period of time	☐

14. Which of the following positions do you hold on the District Management Team?

chairman ☐)
ordinary member ☐) Please go to question 15.

the team does not have such positions ☐ Please go to question 17

15. How are the chairman and vice-chairman of the District Management Team selected?

elected by District Management Team members ☐

they take their turn by rotation ☐

another method (please specify) ☐

16. For how long is the appointment of the chairman and vice-chairman of the District Management Team?

for one year or less ☐

for between one and two years ☐

for two or more years ☐

for an unspecified period of time ☐

17. Does your District Management Team ever discuss papers produced by members?

Yes ☐ please go to question 18

No ☐ please go to question 19

18. How often do you produce papers for the District Management Team?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

19. Approximately how many hours a week do you spend on your duties as a member of the District Management Team?

20. How frequently are District Management Team meetings held?

Weekly	☐
Fortnightly	☐
Every three weeks	☐
Monthly	☐
Other (please specify)	☐

21. How long does a District Management Team meeting usually last?

22. How often do you contact the following District Management Team members between meetings?

	Frequently	Sometimes	Seldom	Never
District Administrator	☐	☐	☐	☐
District Nursing Officer	☐	☐	☐	☐
District Community Physician	☐	☐	☐	☐
District Finance Officer	☐	☐	☐	☐
Consultant Member	☐	☐	☐	☐

23. How often do the following District Management Team members contact you between meetings?

	Frequently	Sometimes	Seldom	Never
District Administrator	☐	☐	☐	☐
District Nursing Officer	☐	☐	☐	☐
District Community Physician	☐	☐	☐	☐
District Finance Officer	☐	☐	☐	☐
Consultant Member	☐	☐	☐	☐

24. Which one of the following descriptions most closely approximates to the way in which you see your role on the District Management Team?

An elected representative of the District Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the District Medical Committee who do not agree to be bound by the decisions he is party to. ☐

An elected representative who is a member of the District Management Team and a typical G.P. and cannot speak for the G.Ps in his district nor make decisions on their behalf. ☐

How would you explain your role on the District Management Team?

25. To whom do you feel you are most accountable as the G.P. member of the District Management Team?

26. Do you have any particular goals which you aim to achieve during your time on the District Management Team?

Yes ☐ please go to question 27

No ☐ please go to question 28

27. Could you briefly describe the goals which you aim to achieve while you are on the District Management Team?

28. Do you believe that significant changes are required in the pattern of expenditure in your district given the present cash limits in operation?

Yes ☐

No ☐

29. Do you believe that the District Management Team is capable of producing significant changes in the pattern of health care delivery in your district?

Yes ☐

No ☐

30. The following statements refer to possible ways of dealing with disagreements or differences of interest in the District Management Team. Please indicate all those which your team has used.

a. One of us sees disagreement coming and manages to steer the team around the issue ☐

b. We avoid discussing issues that are likely to be contentious. ☐

c. We listen to each member's contribution and come to a compromise decision. ☐

d. We agree to differ. ☐

e. We defer the decision for as long as possible to allow reconsideration. ☐

f. We abide by the decision of the member in whose speciality the problem lies. ☐

31. Which one of the above statements best describes your District Management Team?

a.	b.	c.	d.	e.	f.
☐	☐	☐	☐	☐	☐

32. Has your District Management Team ever referred a matter to the Area Health Authority for resolution?

Yes ☐

No ☐

33. Have you as a District Management Team member ever made use of your power of veto?

Yes ☐

No ☐

34. Have you done anything to find out what the G.Ps. in your district regard as the most important priorities for the District Management Team?

Yes ☐ please go to question 35

No ☐ please go to question 36

35. What have you done to find out what G.Ps. regard as the most important priorities for the District Management Team?

36. How often do you produce written accounts of District Management Team activity for the G.Ps. who practise in your area?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

37. How often do G.Ps. in your district approach you about district business and how do they go about it?

	Frequently	Sometimes	Seldom	Never
By personal contact	☐	☐	☐	☐
By telephone	☐	☐	☐	☐
In writing	☐	☐	☐	☐

38. What do you think are the most important policies which G.Ps. would like the District Management Team to implement?

a. In the immediate future

b. In the long-term

39. How often do you approach the following persons for advice about District Management Team matters?

	Frequently	Sometimes	Seldom	Never
Members of other DMTs	☐	☐	☐	☐
Members of the Area Team of Officers	☐	☐	☐	☐
Members of the FPC	☐	☐	☐	☐
Members of the Local Medical Committee	☐	☐	☐	☐
The previous GP DMT Member	☐	☐	☐	☐
The Community Health Council	☐	☐	☐	☐
Chairman of the Area Health Authority	☐	☐	☐	☐

Are there any others whom you approach for advise about District Management Team matters.

40. Would you be prepared, in principle, to complete a diary of your District/Area Management Team activities for about a fortnight?

Yes ☐

No ☐

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr D. Perkins

The Registry,
University of Kent at Canterbury
CANTERBURY
Kent

If you have any further comments about any of the questions raised in this questionnaire please write them below.

THANK YOU VERY MUCH FOR YOUR HELP

D.

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer by ticking the appropriate box or boxes. Where there is no box provided please write your answers in the space below the question. If you work in a single district area please read "Area" where district is mentioned in the questionnaire i.e. Area Management Team and Area Medical Committee. There is room for any additional comments at the end of the questionnaire.

To be answered by the District Administrator

1. When did your present appointment as District Administrator commence?

1974	☐
1975	☐
1976	☐
1977	☐
1978	☐
1979	☐

2. Does the District Management Team have a chairman?

Yes	☐	please go to question 3
No	☐	please go to question 7

3. Which member of the District Management Team is currently the chairman?

District Administrator	☐
District Finance Officer	☐
District Nursing Officer	☐
District Community Physician	☐
GP member	☐
Consultant member	☐

4. Which of the following individuals have been chairman of the District Management Team in the past?

District Administrator	☐
District Finance Officer	☐
District Nursing Officer	☐
District Community Physician	☐
GP member	☐
Consultant member	☐

5. How is the chairman of the District Management Team selected?

Elected by team members	☐
They take their turn by rotation	☐
Another method (please specify)	☐

6. For how long is the appointment of the chairman of the District Management Team?

For one year or less	☐
For between one and two years	☐
For two or more years	☐
For an unspecified period of time	☐

7. How frequently are District Management Team meetings held?

Weekly	☐
Fortnightly	☐
Every three weeks	☐
Monthly	☐
Other (please specify	☐

8. How long does a District Management Team meeting usually last?

9. Does the District Management Team agenda regularly include minutes from the following committees?

	Yes	No
Family Practitioner Committee	☐	☐
Local Medical Committee	☐	☐
District Medical Committee	☐	☐
Health Care Planning Team	☐	☐
Cogwheel Divisions	☐	☐
Medical Executive Committee	☐	☐
Others (please specify)	☐	☐

10. Does your District Management Team ever discuss papers produced by its members?

Yes ☐ please go to question 11

No ☐ please go to question 12

11. How often do you produce papers for the District Management Team?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

12. The following statements refer to possible ways of dealing with disagreements or differences of interest in the District Management Team. Please indicate <u>all</u> those which your team has used.

a. One of us sees disagreement coming and manages to steer the team around the issue. ☐

b. We avoid discussing issues that are likely to be contentious. ☐

c. We listen to each member's contribution and come to a compromise decision. ☐

d. We agree to differ. ☐

e. We defer the decision for as long as possible to allow reconsideration. ☐

f. We abide by the decision of the member in whose speciality the problem lies. ☐

13. Which one of the above statements best describes your District Management Team?

☐ ☐ ☐ ☐ ☐ ☐

14. Has your District Management Team ever referred a matter to the Area Health Authority for resolution?

Yes ☐
No ☐

15. Have you as a District Management Team member ever made use of your power of veto?

Yes ☐
No ☐

16. Does the District Management Team produce edited minutes or reports for circulation to groups and individuals who are not members of the team?

Yes ☐ please go to question 17
No ☐ please go to question 18

17. To whom are these minutes or reports distributed?

Area Health Authority ☐
District Medical Committee ☐
Family Practitioner Committee ☐
Local Medical Committee ☐
Health Care Planning Teams ☐
Cogwheel Divisions ☐
General Practitioners ☐
Community Health Council ☐
Medical Executive Committee ☐
Others (please specify) ☐

18. Has the team attended any management or team development courses?

Yes ☐

No ☐

19. How often do you contact the following District Management Team members between meetings?

	Frequently	Sometimes	Seldom	Never
District Finance Officer	☐	☐	☐	☐
District Nursing Officer	☐	☐	☐	☐
District Community Physician	☐	☐	☐	☐
GP member	☐	☐	☐	☐
Consultant member	☐	☐	☐	☐

20. How often do the following District Management Team members contact you between meetings?

	Frequently	Sometimes	Seldom	Never
District Finance Officer	☐	☐	☐	☐
District Nursing Officer	☐	☐	☐	☐
District Community Physician	☐	☐	☐	☐
GP member	☐	☐	☐	☐
Consultant member	☐	☐	☐	☐

21. Does the GP member of your District Management Team have the use of an office on the same site as the offices of the District Team of Officers?

Yes ☐

No ☐

22. Which one of the following descriptions most clearly expresses the way in which you see the role of the GP member of the District Management Team?

An elected representative of the District Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the District Medical Committee who do not agree to be bound by the decisions he is party to. ☐

An elected representative who is a member of the District Management Team and a typical GP and cannot speak for the GPs in his district nor make decisions on their behalf. ☐

How would you explain the role of the GP member of the DMT

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr. D. Perkins

The Registry,
University of Kent at Canterbury,
Canterbury,
Kent.

If you have any further comments about any of the questions raised in this questionnaire please write them below.

THANK YOU VERY MUCH FOR YOUR HELP.

B.

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer by ticking the appropriate box or boxes. Where there is no box provided please write your answer in the space below the question. If you work in a single district area please read "Area" where district is mentioned in the questionnaire i.e. Area Management Team and Area Medical Committee. There is room for any additional comments at the end of the questionnaire.

<u>To be answered by the secretary of the District Medical Committee or Area Medical Committee in Single District Areas.</u>

1. What is the official description of your post?

2. When did your current appointment commence?

3. When did you become secretary of the District Medical Committee?

1974 ☐
1975 ☐
1976 ☐
1977 ☐
1978 ☐
1979 ☐

2.

The following questions concern the District Medical Committee and its procedures.

4. How many of the following people are members of the District Medical Committee? Please also indicate the number of vacancies alongside each category.

	Number of members	Vacancies
Consultants	☐	☐
General Practitioners	☐	☐
Community Physicians	☐	☐
Junior Hospital Doctors	☐	☐
University Representatives	☐	☐
Pharmacists	☐	☐
Opticians	☐	☐
Nurses	☐	☐
Others (please specify)	☐	☐

5. What is the average attendance at a District Medical Committee Meeting?

6. How often do District Medical Committee meetings take place?

- Fortnightly ☐
- Monthly ☐
- Two monthly ☐
- Three monthly ☐
- Other (please specify) ☐

7. What is the status of the current chairman of the District Medical Committee?

Consultant ☐

General Practitioner ☐

Other (please specify) ☐

8. What is the status of the current vice-chairman of the District Medical Committee?

Consultant ☐

General Practitioner ☐

Other (please specify) ☐

9. How are the chairman and vice-chairman of the District Medical Committee selected?

Elected by DMC members ☐

They take their turn by rotation ☐

Another method (please specify) ☐

10. For how long is the appointment of the chairman and vice-chairman of the District Medical Committee?

For one year or less ☐

For between one and two years ☐

For two or more years ☐

For an unspecified period of time ☐

11. Who is responsible for compiling the agenda for District Medical Committee meetings?

- Chairman ☐
- Vice-chairman ☐
- Chairman and vice-chairman ☐
- Other (please specify) ☐

12. How often do the following people contribute items for the District Medical Committee agenda?

	Frequently	Sometimes	Seldom	Never
Chairman	☐	☐	☐	☐
Vice-chairman	☐	☐	☐	☐
District Medical Committee members	☐	☐	☐	☐

13. Does the District Medical Committee agenda regularly include minutes from the following groups?

- Family Practitioner Committee ☐
- Local Medical Committee ☐
- Health Care Planning Teams ☐
- Cogwheel Divisions ☐
- District Management Team ☐
- Community Health Council ☐
- Others (please specify) ☐

14. How does the District Medical Committee arrive at decisions or policies?

- Only by consensus ☐
- By majority vote ☐

15. The following statements refer to possible ways of dealing with disagreements or differences of interest at District Medical Committee meetings. Please indicate those which best describe the District Medical Committee.

a. One of us sees disagreement coming and manages to steer the Committee around the issue. ☐

b. We avoid discussing issues that are likely to be contentious. ☐

c. We listen to each members contribution and come to a compromise decision. ☐

d. We agree to differ. ☐

e. We defer the decision for as long as possible to allow reconsideration. ☐

f. We abide by the decision of the member in whose specialty the problem lies. ☐

16. Which one of the above statements best describes your District Medical Committee?

a.	b.	c.	d.	e.	f.
☐	☐	☐	☐	☐	☐

17. Does the District Medical Committee produce minutes?

Yes ☐ please go to question 18

No ☐ please go to question 19

18. To which of the following people are District Medical Committee minutes distributed?

District Management Team ☐

Area Health Authority ☐

Area Team of Officers ☐

District General Practitioners (not members of DMC) ☐

Medical Executive Committee ☐

Family Practitioner Committee ☐

Local Medical Committee ☐

Community Health Council ☐

Others (please specify) ☐

19. Has the District Medical Committee agreed on any particular issues which it wishes the District Management Team to pursue?

Yes ☐ please go to question 20

No ☐ please go to question 21

20. How often does the District Medical Committee review progress on these issues?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

21. How often do you contact the following people between District Medical Committee meetings?

	Frequently	Sometimes	Seldom	Never
GP member of District Management team	☐	☐	☐	☐
Consultant member of District Management team	☐	☐	☐	☐

23. How often do the clinical members of the District Management Team bring issues from the DMT to the District Medical Committee for discussion?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

24. How often do the clinical members of the District Management Team report on DMT activities to the District Medical Committee and what form does it take?

	Frequently	Sometimes	Seldom	Never
A written report	☐	☐	☐	☐
A spoken report	☐	☐	☐	☐

25. Which one of the following descriptions most closely expresses your understanding of the role of the GP member of the District Management Team?

An elected representative of the District Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the District Medical Committee who do not agree to be bound by the decisions he is party to. ☐

An elected representative who is a member of the District Management Team and a typical GP and cannot speak for the GPs in his district nor make decisions on their behalf. ☐

How would you explain the role of the GP clinical member on the District Management Team?

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr. D. Perkins

The Registry
University of Kent at Canterbury
CANTERBURY Kent.

If you have any further comments about any of the questions raised in this questionnaire please write them below.

THANK YOU VERY MUCH FOR YOUR HELP.

The General Practitioner Questionnaire

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer by ticking the appropriate box or boxes. Where there is no box provided please write your answer in the space below the question. If you work in a single district area please read "Area" where district is mentioned in the questionnaire i.e. Area Management Team and Area Medical Committee. There is room for any additional comments at the end of the questionnaire.

1. How many partners are there in your practice including yourself?

one	☐
two	☐
three	☐
four or more	☐

2. In which year did you commence general practice?

3. In which year did you commence general practice in this district?

4. Are you currently a member or have you ever been a member of any of the following groups?

	currently a member	have been a member
Family Practitioner Committee	☐	☐
Local Medical Committee	☐	☐
Health Care Planning Team	☐	☐
Community Cogwheel Division	☐	☐
District Medical Committee	☐	☐
District Management Team	☐	☐

5. Do you have the opportunity to take part in the selection of GP members of the District Medical Committee?

yes	☐	please go to question 6
no	☐	please go to question 7

6. How can you take part in the selection of the GP members of the District Medical Committee?

7. Have you ever contributed an item for the District Medical Committee agenda?

yes ☐

no ☐

8. Do you see either a full or an edited version of the District Medical Committee minutes?

yes ☐

no ☐

9. Which of the following committees or groups do you regard as the most important forum for representing the interests of yourself and your fellow GPs in the district?

Family Practitioner Committee ☐

Local Medical Committee ☐

District Medical Committee ☐

District Management Team ☐

Other (please specify) ☐

10. Do you believe that significant changes are required in the pattern of expenditure in your district given the present cash limits in operation?

yes ☐ please go to question 11

no ☐ please go to question 13

11. In what areas of provision do you think that expenditure might be reduced?

12. In what areas of provision do you think that expenditure might be increased?

13. Do you believe that the District Management Team is capable of producing significant changes in the pattern of health care delivery in the district?

yes ☐

no ☐

14. What do you consider are the most important matters that the District Management Team should be considered for immediate action?

15. What do you think are the most important matters that the District Management Team should be considering for future action?

16. Have you ever contacted the GP member of the District Management Team?

yes ☐ please go to question 17

no ☐ please go to question 18

17. Why did you contact the GP member of the District Management Team?

please go to question 19

18. Can you give an example of a matter about which you might approach the GP member of the District Management Team?

19. Has the GP member of the District Management Team ever contacted you?

yes	☐	please go to question 20
no	☐	please go to question 21

20. Has the GP member of the District Management Team ever contacted you for any of the following purposes? Please tick all that apply.

To ask your opinion about which priorities the District Management Team should follow	☐
To ask your advice in a matter in which you were personally involved	☐
To ask your advice because of your expertise or experience	☐
To seek information	☐

21. Do you receive reports or minutes of District Management Team activity from the GP member of the District Management Team?

yes	☐	please go to question 22
no	☐	please go to question 24

22. What form does this report take?

A circular written to GPs ☐

A report in a newsletter ☐

Other (please specify) ☐

23. Do you think that this report is of sufficient length and depth to be of any use to you?

yes ☐) please go to question 25

no ☐)

24. Do you feel that a regular report of District Management Team activity written by the GP member of the District Management Team would be of any use to you?

yes ☐

no ☐

25. Which one of the following descriptions most closely expresses the way in which you see the role of the GP member of the District Management Team?

An elected representative of the District Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound ☐

An elected representative appointed to speak for the District Medical Committee who do not agree to be bound by the decisions he is party to ☐

An elected representative who is a member of the District Management Team and a typical GP and cannot speak for the GPs in his district nor make decisions on their behalf ☐

Would you like to make any further comments on this role?

26. Are you satisfied with the form of representative machinery for expressing the interests of GPs in the management of the district?

yes ☐

no ☐ please go to question 27

27. Why are you dissatisfied with the way in which GP's views are expressed in District Management?

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr. D. Perkins,
The Registry,
University of Kent at Canterbury,
Canterbury, Kent.

If you have any further comments about any one of the questions raised in this questionnaire please write them below.

The Local Medical Committee Secretary Questionnaire SDA E

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer by ticking the appropriate box or boxes. Where there is no box provided please write your answer in the space below the question. There is room for any additional comments at the end of the questionnaire.

To be answered by the Secretary of the Local Medical Committee

1. What is your current occupation or profession?
e.g. General Practitioner, Solicitor, etc.

2. When did your appointment as Secretary of the Local Medical Committee commence?

3. Is your appointment as Secretary of the LMC full-time or part-time?

Full-time ☐ please go to question 5

Part-time ☐ please go to question 4

4. How many hours per week do you spend as Secretary of the Local Medical Committee?

The following questions concern the Local Medical Committee and its procedures

5. How many of the following people are members of the Local Medical Committee? Please also indicate those who are co-opted members.

	Number of Elected Members	Number of Co-opted Members
General Practitioners	☐	☐
Consultants	☐	☐
Community Physicians	☐	☐
Junior Hospital Doctors	☐	☐
General Practitioner Trainees	☐	☐
University Representatives	☐	☐
Pharmacists	☐	☐
Opticians	☐	☐
Nurses	☐	☐
Others (please specify)	☐	☐
	☐	☐
	☐	☐

6. What is the average number of people attending each Local Medical Committee Meeting?

7. How often do Local Medical Committee Meetings take place?

Monthly ☐

Every two months ☐

Quarterly ☐

Other (please specify) ☐

.....

8. Who is responsible for compiling the agenda for Local Medical Committee Meetings?

Chairman ☐

Chairman and Vice Chairman ☐

Chairman and Secretary ☐

Others ☐
(please specify)

.....

9. How often do the following people contribute items for the Local Medical Committee Agenda?

	Frequently	Sometimes	Seldom	Never
Chairman of Local Medical Committee	☐	☐	☐	☐
Secretary of Local Medical Committee	☐	☐	☐	☐
General Practitioner Members	☐	☐	☐	☐
Consultant Members	☐	☐	☐	☐
Community Physicians	☐	☐	☐	☐
Junior Hospital Doctors	☐	☐	☐	☐
General Practitioner Trainees	☐	☐	☐	☐
University Representatives	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐
Opticians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Others (please specify)	☐	☐	☐	☐
.....	☐	☐	☐	☐
.....	☐	☐	☐	☐
.....	☐	☐	☐	☐

10. Does the Local Medical Committee Agenda regularly include minutes from the following groups?

Family Practitioner Committee ☐

Area Health Authority ☐

Area Management Team ☐

Area Medical Committee ☐

Medical Execurive Committee, or ☐

Medical Staff Committee ☐

Community Health Council ☐

11. How does the Local Medical Committee arrive at decisions or policies?

Only by Consensus ☐

By Majority vote ☐

12. The following statements refer to possible ways of dealing with disagreements or differences of interest at Local Medical Committee meetings. Please indicate those which best describe the Local Medical Committee.

(a) The chairman usually sees disagreement coming and manages to steer the committee around the issue. ☐

(b) We avoid discussing issues that are likely to be contentious. ☐

(c) We discuss the matter thoroughly and then come to a compromise decision. ☐

(d) We agree to differ ☐

(e) We defer the decision for as long as possible to allow reconsideration ☐

(f) We take specialist advice and usually abide by that advice ☐

13. Which one of the above statements best describes your Local Medical Committee?

a	b	c	d	e	f
☐	☐	☐	☐	☐	☐

14. Does the Local Medical Committee produce minutes?

Yes ☐ please go to question 15

No ☐ please go to question 16

15. To which of the following people are Local Medical Committee minutes distributed?

Family Practitioner Committee ☐

Area Health Authority ☐

Area Management Team ☐

Area Medical Committee ☐

Medical Executive Committee or ☐

Medical Staff Committee ☐

Community Health Council ☐

Others (please specify) ☐

.....

.....

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.....

The following questions concern the general practitioner member of the Area Management Team

16. Is the General Practitioner member of the Area Management Team a member of the Local Medical Committee?

Yes ☐

No ☐

17. Does the Local Medical Committee select the General Practitioner member of the Area Management Team?

Yes ☐ please go to question 18

No ☐ please go to question 19

18. How does the Local Medical Committee select the General Practitioner member of the Area Management Team?

By election ☐

By nomination of full LMC ☐

Other method (please describe) ☐

19. How often does the General Practitioner member of the Area Management Team bring issues to the Local Medical Committee for discussion?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

20. How often does the General Practitioner member of the Area Management Team report on AMT activities to the Local Medical Committee and what form does it take?

	Frequently	Sometimes	Seldom	Never
A written report	☐	☐	☐	☐
A spoken report	☐	☐	☐	☐

21. Does the General Practitioner member of the Area Management Team hold any office on the Local Medical Committee?

Yes ☐ please go to question 22

No ☐ please go to question 23

22. Which office does the General Practitioner member of the Area Management Team hold on the Local Medical Committee,

23. Which one of the following descriptions most closely expresses your understanding of the role of the General Practitioner member of the Area Management Team?

An elected representative of the Local Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the Local Medical Committee who do not agree to be bound by the decisions he is party to. ☐

An elected representative who is a member of the Area Management Team and a typical GP and cannot speak for the GPs in his area nor make decisions on their behalf ☐

An elected representative of the Area Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound ☐

An elected representative appointed to speak for the Area Medical Committee who do not agree to be bound by the decisions he is party to. ☐

24. How would you explain th e role of the General Practitioner member of the Area Management Team?

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr. D. Perkins

The Registry,
University of Kent at Canterbury,
Canterbury, Kent.

If you have any further comments about any of the questions raised in this questionnaire please write them below.

THANK YOU VERY MUCH FOR YOUR HELP.

The Local Medical Committee Secretary Questionnaire MDAs E

The majority of questions have a choice of answers provided on the questionnaire. Please indicate your answer or answers by ticking the appropriate box or boxes. Where there is no box provided please write your answer in the space below the question. There is room for any additional comments at the end of the questionnaire.

To be answered by the Secretary of the Local Medical Committee

1. What is your current occupation or profession? e.g. General Practitioner, Solicitor, etc.

2. When did your appointment as secretary of the Local Medical Committee commence?

3. Is your appointment as secretary of the Local Medical Committee full-time or part-time?

full-time ☐ please go to question 5

part-time ☐ please go to question 4

4. How many hours per week do you spend as secretary of the Local Medical Committee?

The following questions concern the Local Medical Committee and its procedures

5. How many of the following people are members of the Local Medical Committee? Please also indicate those who are co-opted members.

	Number of Elected Members	Number of Co-opted Members
General Practitioners	☐	☐
Consultants	☐	☐
Community Physicians	☐	☐
Junior Hospital Doctors	☐	☐
General Practitioner Trainees	☐	☐
University Representatives	☐	☐
Pharmacists	☐	☐
Opticians	☐	☐
Nurses	☐	☐
Others (Please specify)	☐	☐

6. What is the average number of people attending each Local Medical Committee Meeting?

7. How often do Local Medical Committee meetings take place?

- Monthly ☐
- Every two months ☐
- Quarterly ☐
- Other (Please specify) ☐

.....

8. Who is responsible for compiling the agenda for Local Medical Committee meetings?

Chairman	☐
Chairman and Vice Chairman	☐
Chairman and Secretary	☐
Others (Please specify)	☐

9. How often do the following people contribute items for the Local Medical Committee Agenda?

	Frequently	Sometimes	Seldom	Never
Chairman of Local Medical Committee	☐	☐	☐	☐
Secretary of Local Medical Committee	☐	☐	☐	☐
General Practitioner Members	☐	☐	☐	☐
Consultant Members	☐	☐	☐	☐
Community Physicians	☐	☐	☐	☐
Junior Hospital Doctors	☐	☐	☐	☐
General Practitioner Trainees	☐	☐	☐	☐
University Representatives	☐	☐	☐	☐
Pharmacists	☐	☐	☐	☐
Opticians	☐	☐	☐	☐
Nurses	☐	☐	☐	☐
Others (Please specify)	☐	☐	☐	☐
.....	☐	☐	☐	☐
.....	☐	☐	☐	☐
.....	☐	☐	☐	☐

10. Does the Local Medical Committee Agenda regularly include minutes from the following groups?

Family Practitioner Committee	☐
Area Health Authority	☐
Area Medical Committee	☐
District Management Teams	☐
District Medical Committees	☐
Medical Executive Committees or	☐
Medical Staff Committees	☐
Community Health Councils	☐

11. How does the Local Medical Committee arrive at decisions or policies?

Only by consensus	☐
By majority vote	☐

12. The following statements refer to possible ways of dealing with disagrements or differences of interest at Local Medical Committee meetings. Please indicate those which best describe the Local Medical Committee.

(a) The chairman usually sees disagreement coming and manages to steer the committee around the issue ☐

(b) We avoid discussing issues that are likely to be contentious ☐

(c) We discuss the matter thoroughly and then come to a compromise decision ☐

(d) We agree to differ ☐

(e) We defer the decision for as long as possible to allow reconsideration ☐

(f) We take specialist advice and usually abide by that advice ☐

13. Which one of the above statements best describes your Local Medical Committee?

a	b	c	d	e	f
☐	☐	☐	☐	☐	☐

14. Does the Local Medical Committee produce minutes?

Yes ☐ please go to question 15

No ☐ please go to question 16

15. To which of the following people are Local Medical Committee minutes distributed?

Family Practitioner Committee ☐

Area Health Authoirty ☐

Area Team of Officers ☐

Area Medical Committee ☐

District Management Teams ☐

District Medical Committees ☐

Medical Executive Committees or ☐

Medical Staff Committees ☐

Community Health Councils ☐

Others ☐
(Please specify)

.....

.....

16. Does the Local Medical Committee have district sub-committees?

Yes ☐ please go to question 17

No ☐ please go to question 23

17. Are these districts coterminous with National Health Service districts?

Yes ☐

No ☐

18. How frequently do district sub-committees meet?

26. How often do the General Practitioner members of the District Management Team bring issues from the DMTs for discussion?

Frequently	Sometimes	Seldom	Never
☐	☐	☐	☐

27. How often do the General Practitioner members of the District Management Teams report on DMT activities to the Local Medical Committee and what form does it take?

	Frequently	Sometimes	Seldom	Never
A written report	☐	☐	☐	☐
A written report	☐	☐	☐	☐
A spoken report	☐	☐	☐	☐

28. Do any of the General Practitioner members of the District Management Teams hold offices on the Local Medical Committee?

Yes ☐ please go to question 29

No ☐ please go to question 30

29. Which offices on the Local Medical Committee are held by General Practitioner members of the District Management Teams?

30. Which one of the following descriptions most closely express your understanding of the role of the General Practitioner member of the District Management Team?

An elected representative of the Local Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the Local Medical Committee who do not agree to be bound by the decisions he is party to. ☐

An elected representative who is a member of the Area Management Team and a typical GP and cannot speak for the GPs in his district nor make decisions on their behalf. ☐

An elected representative of the District Medical Committee who is authorised to make decisions on their behalf to which they agree to be bound. ☐

An elected representative appointed to speak for the District Medical Committee who do not agree to be bound by the decisions he is party to. ☐

31. How would you explain the role of the General Practitioner member of the District Management Team?

Please check that you have answered all the questions and then return the completed questionnaire in the enclosed envelope to:

Mr. D. Perkins

The Registry
University of Kent at Canterbury
CANTERBURY Kent.

If you have any further comments about any of the questions raised in this questionnaire please write them below.

THANK YOU VERY MUCH FOR YOUR HELP.

Abbreviations

AA	Area Administrator
AHA	Area Health Authority
AMC	Area Medical Committee
AMO	Area Medical Officer
AMT	Area Management Team
ANO	Area Nursing Officer
A/RC	Area or Regional Co-ordinator
ATO	Area Team of Officers
BIOSS	Brunel Institute of Organisation and Social Studies
CEO	Chief Executive Officer
CHC	Community Health Council
DA	District Administrator
DCP	District Community Physician
DFO (DT)	District Finance Officer (District Treasurer)
DHSS	Department of Health and Social Security
DHA	District Health Authority
DMC	District Medical Committee
DMT	District Management Team
DNO	District Nursing Officer
FPC	Family Practitioner Committee
GAA	General Administrative Assistant
GM/C	General Manager or Co-ordinator
GMSC	General Medical Services Committee
GP	General (Medical) Practitioner
HC	Health Circular
HMSO	Her Majesty's Stationery Office
HSORU	Health Services Organisation Research Unit

LMC	Local Medical Committee
MAC	Medical Advisory Committee
MEC	Medical Executive Committee
MSC	Medical Staff Committee
NHS	National Health Service
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority
RMO	Regional Medical Officer.