sponsorship, or they will die. Reduced budgets mean fewer staff with more students, reducing the time available for thinking about research which could generate grants. So the vicious spiral begins, the only outcome of which is not increased efficiency but a general decline in academic standards. Universities begin to share the load by creating taught modules which can be exchanged for credits in other teaching institutions. Yet, as the Dean of King's College has shown[4], this devalues the distinctive role of the university. In name we can make all our polytechnics into universities; in reality we are turning all our universities into polytechnics.

Second, cost cutting leads to increased risk taking and a decline in ethical standards. The Ombudsman has given two successive adverse reports about the administration of the Child Support Agency. Simple administrative mistakes have been made. Processing of payments has been unreasonably delayed. Yet what is the Agency's response? Because of the need to meet further efficiency targets, more staff cuts are planned! In the health care field the absurdities are even more obvious. In response to an increasing demand for accident and emergency treatment, the Audit Commission proposes that the number of A&E units can be reduced. Presumably if patients with 'trivial conditions' have further to travel they will be deterred from using the service, which will then become more 'resource efficient'! Present anxieties about the availability of intensive care beds is a further inevitable consequence of the myth of management efficiency. By reducing the number of beds to 'normal' or average, occupancy money is saved, but the ability to cope with upward trends of unforeseen emergencies is lost. Patients die *en route* to a distant hospital. Is this ethically acceptable? Even more disturbing is care of the elderly. A recent survey of residential homes reported in the *British Medical Journal*[5] found that 24% of residents were receiving drugs to control their behaviour. The authors found that in 88% use of the drugs fell outside the guidelines for their appropriate use. If residents are more malleable, fewer staff are needed to care for them and costs are reduced.

One or two voices are now being raised against this management myth[1]. Even one of the leading apostles of the myth now believes that the concentration on cost cutting and sacking is out of date[6].

Conclusion

This article has tried to show that those exposed to management training should maintain a healthy scepticism about what is taught and what it can achieve. It has also attempted to show that, until an outdated concept of management in the NHS is replaced by one based on those prevalent in national economies more successful than the United Kingdom, and that seeks the active involvement and participation of the key workers within the health care system, doctors would be well advised to maintain their present resistance to the system. However highly motivated, it is extremely unlikely that any individual doctor will be able seriously to improve the system from within.

Doctors also need to understand that management is not value neutral. It is easy to assume that many of the issues discussed in this article are technical and only peripherally related to medicine. Unfortunately this is not so[7]. The structure of the health care system critically affects the professional ethics of those working within it. One or two brief examples have been given. Many more exist. Jeffrey Stout[8], a prominent writer in ethics, believes that the commercial market is a far more serious threat to ethical behaviour than the different value systems among health professionals. They need to be on their guard to ensure that the insidious and pervasive thinking of market culture does not damage ethical values to a point that everyone would recognise to be wrong. Since management has been the means to lever the market culture into the NHS, all health professionals need to recognise for what they really are the myths that managers believe.

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In response

I am sure many, perhaps most, readers of the Journal will have enjoyed Stuart Horner's article in this issue of the *Journal.* Manager-bashing is fun (another good way to annoy us is to call us 'administrators').

I have sympathy with Dr Horner's frustration at managers who take arbitrary decisions. Continual overstatement of his case, however, weakens its effect. The most bizarre example is the suggestion that 'Doctors admitting emergencies to their hospitals aren't really trying if their patients have not achieved between five and nine episodes within 24 hours of

admission'. My authority keeps a close eye on the admissions/episodes ratio, and was the first to publish evidence of abuse; but for most of our trusts the ratio is about 1:1.07 – that is 7 extra episodes per 100 admissions. Perhaps my local hospital doctors aren't really trying?

Dr Horner presents what he describes as a series of myths, moving readily between those believed by NHS managers and those by managers in other sectors. His basic proposition is that the NHS is different in kind, and that supermarket management will not work in the complex relationship between clinicians and patients. I agree, and argued the same point with an MP on the Public Accounts Committee who wanted to know why NHS operations were any different from a car's trip to the garage. His secondary proposition is that there are flaws in the managerial ethos, wherever it is practised in this country (in sharp distinction, it would seem, from the tiger economies of the Pacific Rim, which had the good sense to model themselves on the 1974 NHS consensus model).

The problem with Dr Horner's analysis, apart from its partiality, is its narrow concept of managers. Apart from distinguishing theory Y from theory X managers, (the former, among whom I count myself, are apparently like red squirrels being overrun by grey) Dr Horner generalises excessively. In reality, managers, whether in the NHS or elsewhere, are no more homogenous entities from the production lines of Henley, Ashridge or the London Business School than patients are like Ford cars. For that matter, NHS consultants and GPs, notwithstanding the efforts of their professional bodies, display individuality on a scale which any NHS manager ignores at peril. And for all their diversity, the most successful clinicians and managers are those who understand the need to work together – not in the outmoded 1974 consensus model, but in true collaboration based on respect.

In my view Dr Horner only partly addresses three key issues. First, resources, whether of money or personnel, are finite, and there will always need to be a managerial process to match finite supply with demand, just as there will always need to be a process whereby society determines what share of the common wealth to allocate to health. Secondly, many of the drivers for change in health care are coming not from managers but from clinicians; the Audit Commission did not invent the proposition that the number of A&E Departments be reduced, but endorsed a clinical opinion on minimum size. Lastly, he fails to draw out the extent to which the much-derided analogy with Sainsburys may have become a reality. A vast amount of information about the NHS, much of which is meaningful, is now available at the centre sufficiently quickly for 'headquarters' managers to know what is going on and to intervene in ways which may well reduce the responsibility of local management. The NHS's bankers, the Treasury, also have these data, and that opportunity.

Clinicians and managers at local level face an increasing need to agree about the best ways of using public resources. If we do not, others will presume to instruct us all.

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It is an interesting new myth that post-1974 consensus management in the NHS has similarities with the paternalistic, collaborative but fundamentally authoritarian corporate cultures of Japan, Korea and the Chinese diaspora. Consensus management is, in fact, a uniquely British eccentricity. Its theoretical foundation derived from the work of Wilfred Brown and Elliot Jacques in an unusual alliance with McKinsey & Co. Wilfred Brown was an exponent of industrial democracy with a powerful mix of philanthropy in the very British tradition of Owen, Rowntree and the John Lewis Partnership. His long time collaborator Elliot Jacques was a psychoanalyst who developed a very elaborate theoretical structure to describe social relationships at work. Wilfred Brown's Glacier Metal Company did not survive the terrible economic onslaught of the 1980s, and neither did NHS consensus management.

Developments in management of the health services in the 1980s and 1990s have, to a large extent, simply been of a piece with developments in society more widely.

Government in the 1980s asserted its political will over public services generally, including professional services such as health and education. Administrators or managers on short-term contracts, whose livelihood in the end depends on political or quasi-political patronage, have been an important instrument to deliver government policy. The barons of the public services and professions have all had cause to feel, from time to time, as 'conquered peoples of a once-great civilisation'.

Performance management of public services and demands for professionals to be more accountable have been a general feature of the last decade. We can deride Charter standards. We all know how simplistic measures can be manipulated. Micro-management of waiting lists or waiting times is irksome and difficult. Nevertheless, very long waiting lists for elective admission have, in fact, disappeared and the vast majority of outpatients do see a doctor within a short period of the appointment time. I cannot think that has been a bad development.

Is it really all that unreasonable to ask a consultant to say when he or she is available for operating lists, ward rounds or outpatient clinics and to let other people know if his or her schedule has to be altered? That is what a job plan does.

McGregor's theory X and theory Y were taught when I went to business school in 1969. McGregor favoured theory Y. He was part of a school of thought which became known as the 'human potential movement'. McGregor's writing was very much part of the optimistic 1960s, when it was bliss to be alive and to be young was very heaven. If McGregor is still taught in business schools I would be surprised if theory Y has been found to be a very good working model for industries which are downsizing and outsourcing as the NHS has been for the last decade.

A better theory of organisation, contingency theory, suggests that different ways and styles of organisation are needed to respond effectively to different circumstances. General management was an effective response to the needs of the 1980s. It was a harsh prescription for harsh times. Later, the NHS reforms of the early 1990s were the expression in the health service of a much wider social movement to increase the power of consumers in relation to suppliers, including suppliers of professional services, and to mimic the dynamic of markets within public sector organisations.

An enterprise which consumes more than £30 billion annually needs to be run in a business-like way, and be able to demonstrate that to its paymasters. We often try to count things that are very difficult to count, and get it wrong. But the NHS cannot avoid having to account for the vast amount of money it has to spend. Nor can we avoid responding to the dominant social trends of the times we are in. But in the drive to be more business-like it can easily be forgotten that health services are not a business.

For me, the most illuminating writer on organisation is Amitai Etzioni, who defined hospitals, along with schools, universities and the church, as 'normative organisations'. Normative organisations are vehicles for custody and transmission of a society's fundamental values. The leadership of a normative organisation rests *de facto* with the leading priests, teachers or doctors who embody the values and knowledge which are the purposes of the organisation. Key to effective management or administration of the economic aspects of such an organisation is that the administrator/manager has internalised its values and recognises the charismatic leadership of the practitioners.

General management in the NHS did fail to acknowledge these fundamentally important differences between management in industry and management in health services, although I think successful general managers all understood the difference. The market reforms of the NHS have stimulated many real improvements in service for patients and in efficiency, but do threaten to subvert the values of the health service.

Management is certainly not value neutral – nothing is. Managers and professionals need to share the same values. We cannot escape the economic, social or political realities of the times in which we live. Management is not a scholarly pursuit, and evidence based management is no more widely practised than evidence-based medicine. Nevertheless, in the modern world management is necessary. It need not be an evil.

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