

# Should medical students learn more about management?

IN 1987, the General Medical Council published as part of its recommendations on training of specialists,<sup>1</sup> a list of the attributes of the independent practitioner. They remain a valid yardstick against which the council's recent recommendations on undergraduate education, *Tomorrow's doctors*, can be judged.<sup>2</sup> For although the attributes represent the combined goals of undergraduate education, postgraduate training and early professional development for doctors in the United Kingdom, the General Medical Council encourage their recommendations on undergraduate education to be seen 'within the context of the overall educational experience and professional development of the doctor'.<sup>2</sup>

In relation to learning about management, the attributes include: 'experience in administration and planning; appropriate use of... resources, and appreciation of... economic and practical constraints affecting... healthcare; and willingness to participate in... bodies which advise, plan and assist the development and administration of medical services'.<sup>1</sup> In contrast, *Tomorrow's doctors* refers only to understanding of 'the organization and provision of health care... and of the economic and practical constraints within which it is delivered'.<sup>2</sup>

This limited scope of undergraduate learning objectives seems educationally unsound; medical students need to acquire skills which will enable them, from the outset, to manage their own learning in order, subsequently, to manage resources and ultimately to develop clinical services. *Tomorrow's doctors* is provoking a fundamental rethink of the undergraduate medical curriculum; the relevance of management expertise rests upon both theoretical and practical arguments. First, there are close parallels between the competencies required by general managers and generalist clinicians; and secondly, there are the realities of professional life in a National Health Service where managers (including clinicians in managerial roles) have come to dominate decision making about major issues.

In its analysis,<sup>2</sup> the General Medical Council goes to the heart of the current problem in undergraduate medical education: a curriculum which is a patchwork of specialist input cannot provide either a coherent basis for postgraduate training or the mainspring of individual professional development into widely diverse professional roles. All doctors need to attain basic generalist competence before this is adapted by training and experience to independent practice in the community or a specialty.

The generalist's approach to problem management has evolved from the need to address undifferentiated problems to the point either of resolution or selective referral to more specialized expertise. Thus, a general medical practitioner confronted by a clinical problem cannot at the outset know whether the problem really exists or is a perceptual disorder of the patient; is the major problem, a smokescreen or a prelude to hidden agendas; has its origins in physical, psychological or social dysfunction; and, above all, is amenable to intervention with the partial information available. Without drawing exact parallels in the work of general management, a little reflection will reveal strong similarities in the undifferentiated nature of problems, in the subjectivity with which they are perceived, in their structural, behavioural and contextual elements, and finally, in the typical availability of limited data.

Similarly, the skills which have evolved among generalists are designed to optimize information gathering, enable broad ana-

lysis of problems and facilitate shared decision making with the patient. Currently, most UK medical schools address these skills in courses on communication and consultation. Nevertheless, subsequent student behaviour suggests that many have learned, merely, to provide medical paternalism with a more acceptable face. Future medical education must prepare students for the increasing requirement in clinical practice to make judgements explicit and to proceed on the basis of informed consent, despite substantial uncertainty and finite resources. This is likely to reinforce in students the need to gather information comprehensively and emphasize the limitations of biological determinism as an explanatory model of human experience of ill health.<sup>3</sup>

Moreover, while much has been made in communication skills teaching of exposition and explanation<sup>4</sup> (so often believed by students to constitute an all-powerful nostrum called reassurance) the reality is that generalists must fashion interpretation to fit patients' underlying fears and expectations. Thereafter, negotiation can begin around acceptable interventions and the need for follow up.<sup>5</sup> Clearly, skills of interpretation and negotiation represent common ground for generalist manager and clinician.

Clinicians are already involved in NHS management at a number of levels: first, operationally as clinical directors,<sup>6</sup> executive partners<sup>7</sup> and advisers to health authorities;<sup>8</sup> secondly, at a more strategic level as executive directors of NHS trusts and health authorities; and finally, if rarely, as chief executives or chairmen. If successors to the present incumbents are to come more naturally to such roles, basic medical education will need to recognize involvement in management as a commonplace reality of professional life.

Moreover, there is a well-established and ubiquitous clinical role with managerial responsibilities: the pattern of organization of general practice in the UK resembles a chain of small businesses, typically with a group of general practitioners in partnership providing clinical services to a defined list of patients both directly and through primary health care teams. Yet few general practitioners emerging from current medical education and training understand corporate governance<sup>9</sup> or possess the skills of team building and leadership, to choose just three examples from the increasingly complex array of management tasks confronting general practitioners,<sup>10</sup> especially fundholders.

This situation is unlikely to be remedied simply by increasing students' exposure to management in NHS trust, health authority, or fundholding practice. There is evidence that medical students are interested in learning about the role of the general practitioner in management;<sup>11</sup> in part, this reflects a need to assess their individual compatibility with an important career option. However, experience of this kind also carries educational risks: practice managers tend to be preoccupied with administration and are not best suited to impart principles;<sup>12</sup> practices tend to reserve governance for partners,<sup>13</sup> with the result that the prevailing managerial culture is typically a benign paternalism; and, finally, where vocational issues are involved students may equate management with optimizing income rather than with wider strategic issues.<sup>14</sup>

Helping medical students to learn what is important in management is not, then, about prescribed experience, much less didactic teaching, but about stimulating latent skills and harnessing motivation, currently an early casualty of the undergraduate course. For example, early encouragement to use skills (of time

management, prioritization and so on) involved in effective, self-directed study should lead to a virtuous circle of demonstrable education gain and heightened motivation. Later, students need to be challenged by specific, academic but service-related tasks such as clinical audit undertaken in small teams.<sup>15</sup> Among the skills required are: analysis of component tasks, delegation, negotiation and presentation. In this way, students learn to manage situations which have an order of complexity and level of significance beyond that of individual patient-doctor interactions.

Soon after qualification doctors experience NHS management at first hand. This has rarely been a happy introduction to a virtual monopoly employer; comparison with commercial organizations reveals just how much the NHS has yet to learn about management of its staff.<sup>16</sup> Little wonder, then, that by this stage recent generations of young doctors have been inclined to compound their ignorance of management with attitudes of lofty indifference or even hostility. This mistrust between managers and doctors has been reinforced by a perception arising from the NHS reforms, that management and medicine in the NHS inhabit different peaks of the moral high ground: the former, value for money; the latter, need before cost. However, there are signs that reconciliation is in the air. Over time, medical education has an important part to play in achieving and sustaining reconciliation. The ideas underpinning *Tomorrow's doctors* suggest that generalist skills which currently are acquired, if at all, during a lifetime of professional development should be seen as forming the core of medical expertise.

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# Living up to expectations?

WHAT would McConaghey,<sup>1</sup> the founding editor of the *Journal*, think of its current progress? He had the courage to establish a journal of scientific record in 1958 despite the paucity of new research findings from general practice at that time. This controversial decision was vindicated only three years later when the *Journal* was included in *Index medicus*, which lists the highest quality and most important biomedical and health sciences journals published throughout the world. This was the first time a general practice journal had been recognized internationally in this way.<sup>2</sup> We believe he would have approved of the *Journal's* continuing commitment to publishing original research in primary care.

The strength of a journal of record can be measured objectively, not only from the number of papers submitted and the wide variety of sources from which they come, but also by the number of its articles which are cited in peer reviewed and referenced scientific papers. The *Science citation index* (Institute for Scientific Information) is the authoritative source of citation data

on journals. The citation count for the *Journal* has risen from 148 in 1983 to 555 10 years later. The Institute for Scientific Information also provides an independent assessment of the influence of a journal: the 'impact factor' measures the frequency with which the 'average article' in a journal has been cited in a particular year. This figure helps to determine the relative usage of a journal and is of interest not only to editors but to authors considering the most appropriate placement for their work. The impact factor data for 1991 demonstrate that of 120 journals in the general and internal medicine category the *Journal* is rated 19th and is the highest ranking general practice journal in the world.

How can we continue to live up to these achievements in an era which is seeing a dramatic increase in research activity in and on general practice together with huge changes in the National Health Service?

In addition to regularly reviewing key indicators we would now like to step back from time to time and look at other aspects