9 Variations on a Theme: clinicians in management in England and the Netherlands
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INTRODUCTION

The impact of health care reforms on the organisational behaviour of hospital doctors is a theme which is attracting considerable attention. Within many of the comparative health care analyses, the changing role of doctors tends to be discussed as an area of key importance (for example, Ham, 1997; Raffel, 1997) and research is being carried out that has as its central focus the medical profession's adaptation to policy changes in different health care systems (van Herk, 1997). Two main influences can be discerned which shape the current debates. First, the literature on the medical profession (Freidson, 1970; 1984; Döhler, 1989; Hafferty and Light, 1995; Larkin, 1995). One of the issues highlighted concerns the form and nature of self-regulation and the importance of clinical autonomy as a mechanism to safeguard professional control. Second, the shift in many countries towards a more managerially oriented health care system has drawn attention to the question of what this signifies for the medical profession: on the one hand, the economic power of managers over doctors is being considered the overriding theme (for example, Flynn, 1992) and, on the other hand, the argument is advanced that, at the micro level, doctors are difficult to control and thus continue to determine the shape of health provisions (Hunter, 1994).

The role of the medical profession within health care organisations across Western countries has not, as yet, reached a stable position, but it is possible to discern a number of trends which indicate the future direction of the relationship between doctors and managers. In this
chapter we will focus, in particular, on the developments within the acute hospital sector in England and the Netherlands. The main reason for selecting these two countries is that doctors are explicitly drawn into managerial decision making because of organisational changes in the structure of health care, and because their professional expertise is used, through the mechanism of 'evidence-based care', in financial decision making. At the same time, important differences need to be considered in terms of the status of doctors and their relationship with third-party payers.

We focus on the acute sector. The pressure to deliver care of an explicitly stated amount and quality forces hospitals, and the doctors working within them, to develop systems which can enumerate activity and measure care processes and outcomes, and this implies greater accountability for medical decision making. The doctor can no longer operate as an individual agent in modern hospitals. Thus the relationships both between the individual doctor and the organisation, and between the doctors as a professional body and the organisation have to be scrutinised. This chapter draws on empirical research carried out in English and Dutch hospitals, examining the changing position of doctors and their representative bodies within hospital organisations. While comparisons are drawn between the two countries, the emphasis is placed on the Dutch situation, as the research data are more detailed and recent.

Briefly the English data were collected in a 650-bedded general hospital, organised in nine directorates, during 1994–6. The research design was an in-depth case study focusing on two directorates and using the other seven as comparative backdrop. Two other trusts were examined in less depth to provide a broader context. This study has been reported elsewhere (Boaden et al., 1995; Ong et al., 1997). The Dutch research was carried out in 1997 and covered nine hospitals across the country. In-depth interviews were carried out with medical managers and senior executive managers (N=24) supported by interviews with four policy analysts. All the material was analysed using the QSR NUD*IST computer-based tool and some of the findings have been reported by Ong and Schepers (1998).

First, the organisational structure of English and Dutch hospitals will be discussed with particular reference to the place of doctors within this structure (see Figures 9.1 and 9.2). This discussion will address the managerial characteristics of the medical role. Second, the manner in