Leading article

Clinical directors of pathology: who are they and what do they direct?

The first Griffiths Report of 1983 recommended substantial changes in the way in which health services were managed.¹ At the core of the proposals were the needs to have clear lines of managerial accountability and to involve consultants more substantially in the management of resources at hospital level. Consequently, a relatively simple hierarchical structure of general management was introduced and a growing number of consultants were drawn into management and quasi-management posts of one sort and another. For pathologists, this was not really new because one or more of their colleagues had always been involved in laboratory management, and an appropriate structure has been spelled out most recently in 1974 in the now famous HSC(IS)16.²

What was not anticipated in 1983, however, was the extent of the freedoms given by Griffiths to develop management structures at local level and the degree to which those freedoms would be used. Throughout the country there are now vastly different management structures within health districts, and some districts and laboratories now face their *second* management reorganisation in the past four years as new district general managers (DGMs) and unit general managers (UGMs) are appointed who wish to adapt district structures to their own particular philosophies of management. In passing, this article extends its sympathy to those pathologists and others now caught up in what seems to them to be an endless cycle of management reorganisations.

It is hard to keep track of every new development, but a sufficient number of recent changes are known to identify the title of "clinical director" as one that is emerging with ever increasing popularity in management structures. This title involves consultants in a range of specialties, not just pathology and radiology, but this article is concerned with its implications for pathology. The clinical director is worthy of attention if only because the title seems to be given to posts that vary enormously in character and responsibility. There is a danger that pathologists may believe, from their local experience, that the title defines a roughly equivalent area of responsibility, but this is certainly not so.

All job descriptions for clinical directors, where they

exist, seem to share a common view that a clinical director is responsible for an undefined concept called "clinical leadership". As no job descriptions define this phrase it is necessary to try to define its meaning in other ways. The most simple is to look at the authority of a clinical director within the management structure, and it is here that the variations are greatest.

Some clinical directors are budget holders and are accountable to the unit general manager for the pathology laboratory service. They direct the service for which they are responsible in the sense that they have managerial accountability for staff within that service, except for the clinical workload of their consultant colleagues. They may delegate substantial day to day management tasks to medical laboratory scientific officers (MLSOs) but their managerial authority is clearly synonymous with their title and responsibilities as director.

At the other end of the scale there are clinical directors in limbo, with no managerial authority over those in the service that they are supposed to direct, and if they retain the title of budget holder it is often strictly spelt out in their job description that they must hand over the day to day running of the budget and its decisions to some other manager, usually an MLSO. If the mainly MLSO staff in their laboratory are accountable to them in any way, there is a reference to clinical accountability while at the same time emphasising that managerial accountability is through an MLSO with a variety of titles to the unit general manager. In these structures the person who was once called a principal MLSO may now be called the laboratory manager or the support services manager, both of whom would be managerially accountable to a unit general manager.

These clinical directors without managerial authority have, in reality, accepted a sham title. They direct nothing, apart from their own junior staff and perhaps their secretaries if they have any, but they can give no instructions. In the clinical field they can ask that this or that is done or that a service is introduced or terminated, and in most of cases this is done because the MLSOs and the MLSO "manager" accepts that it is the right thing to do anyway. Thus people get along together relatively harmoniously and this ability to get along is often used by the clinical director to justify the fact that he/she has allowed all effective *managerial* authority to be excluded from his/her job description.

One recent document went so far as to describe the relationship between a consultant pathologist clinical director and an MLSO support services manager as . . . "a symbiotic relationship in which each feeds off the other to produce an effective and meaningful service . . ." As an attempt to describe management arrangements it is, of course, twaddle, and no one would have apoplexy more quickly than Griffiths himself. In such a district, the first time the clinical director and the support services manager have a serious difference of view there is an impasse because no one has the authority to take the final decision. It is an erosion of medical primacy that one sees occurring in other specialties at the present time, and it results in both people going to the unit general manager or district general manager to appeal for support. When this starts to happen in the districts that have accepted the easy compromise the consultants concerned might ponder on how they themselves have contributed to the decline of medical authority within our health care system.

So far I have ignored what is a most important issue to pathologists—the level at which the clinical director operates. Is he/she a clinical director of a laboratory involving all the specialties in pathology, or is he/she a clinical director of a department and coequal with colleagues who are clinical directors of other departments? This debate has been extensively written about in recent years, and I do not intend to develop the issues again here.³ The Royal College of Pathologists has made its preference for independent departments very clear and there is some slow movement in that direction in the country at the moment.⁴ Most pathologists, however, have had to accept that the pathology laboratory is managed as a single entity with heads of department, who, whatever their title, are managerially accountable to a consultant head of

laboratory with a variety of titles, who in turn is accountable to a unit general manager.

Whether one or both of these levels use the title clinical director is immaterial, what matters is that a clinical director should have the clear managerial authority implied within the Griffiths Report and spelled out in HSC(IS)16. Without it clinical directors do not have the authority to maintain a standard, quality, and range of clinical service when faced with disagreement from technical staff. Such clinical directors are not directors in any sense, because they have nothing to direct. One has sympathy for those consultant pathologists who have compromised with district general managers or unit general managers on the grounds that what they have got is all they could achieve by bargaining. But perhaps the time has come when some issues have to be regarded as too important to be bargainable if we are to retain medical responsibility for pathology services.

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