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Clinicians on the board: What difference does it make?

Gianluca Veronesi*, Ian Kirkpatrick [1], Francesco Vallascas [2]

Leeds University Business School, The University of Leeds, Maurice Keyworth Building, Leeds LS2 9JT, UK

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ABSTRACT

Around the world clinical professionals have increased their involvement in the management of health services. However the evidence to suggest that these changes will lead to improved performance remains fragmented. In this paper we address this matter focussing on the impact of clinicians appointed to the boards of directors of English NHS hospital trusts. Although the number of clinicians involved in the strategic governance of hospital trusts is relatively low by international standards, they do appear to have an impact on overall performance. Drawing on published information from hospital trust annual reports, publicly available performance measures from the Healthcare Commission and data gathered by Dr Foster over a three year period (2006–9), the paper reports two main findings. First, the analysis reveals a significant and positive association between a higher percentage of clinicians on boards and the quality ratings of service providers, especially where doctors are concerned. This positive influence is also confirmed in relation to lower morbidity rates and tests to exclude the possibility of reverse causality (doctors joining boards of already successful organisations). Second, we do not find the same level of support for clinical professions such as nurses and other allied health professions turned directors.

Introduction

The role of health professionals has been subject to marked change in recent years in a context of shifting technology, public expectations, population needs and the management of services (Kuhlmann & Annandale, 2012). The latter has resulted in greater financial constraint, external regulation and competition, although one of the most radical changes have been moves to co-opt doctors and nurses themselves into management roles (Numerato, Salvatore, & Fattore, 2012). Attention has focused on involving clinicians more at the middle tier of hospitals (Braithwaite & Westbrook, 2004) as well as in the strategic direction of health care, through membership of hospital boards or as fund-holders responsible for the commissioning of services. These changes have gone hand in hand with the wider restructuring of health systems, exposing organisations such as hospitals to greater competition for resources and moving them closer to a governance model of private firms (Farrell, 2005).

In much of the literature, this development of 'hybrid' clinical-professional roles is often understood as part of a broader process of re-stratification (Freidson, 1985; Kirkpatrick, Jespersen, Dent, & Neogy, 2009). Attention has concentrated on the emergence of new 'administrative elites' within the clinical professions and how this, in turn, has helped to extend management control over the practice of rank and file professionals, turning 'poachers into gamekeepers' (Harrison & Ahmad, 2000). By contrast, far less attention has been given to the consequences of these developments for the quality of health care. Here the question that arises is how far (if at all) the participation of clinical managers in the governance of health organisations makes a difference to their performance?

Amongst policy makers there is now strong support for the idea that stronger clinical leadership will have positive consequences (Ham, Clark, & Spurgeon, 2011; King's Fund, 2011; Xirasagar, Samuels, & Stoskopf, 2005). This conclusion is also supported by a growing body of international research (see for example, Dorgan et al., 2010). However, questions remain about the specific impact of clinical leadership at more strategic levels. While a number of studies have focused on the dynamics of hospital boards in the US (Goodall, 2011; Prybil, 2006b) with some exceptions (King's Fund, 2012), far less attention has been given to this issue in the English National Health Service (NHS). The results of this research are also inconclusive when it comes to assessing the impact of clinicians on board level decision making.

* Corresponding author. Tel.: +44 (0)113 343 8686.
E-mail addresses: G.Veronesi@leeds.ac.uk (G. Veronesi), I.Kirkpatrick@leeds.ac.uk (I. Kirkpatrick), F.Vallascas@leeds.ac.uk (F. Vallascas).
[1] Tel.: +44 (0)113 343 2611.
[2] Tel.: +44 (0)113 343 4483.

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The aim of this paper is to address these limitations focussing on the relationship between clinical board membership and performance in the context of NHS trust hospitals. Specifically we concentrate on one measure of performance for hospital trusts, namely the rating on the quality of the service provided given by the Healthcare Commission, a semi-independent regulator in the sector (now superseded by the Care Quality Commission). Tests are also conducted using quality measures relating to patient morbidity gathered by Dr Foster, an independent research institute. Building on the work of Goodall (2011), we focus on the qualifications of all board members (executive and non-executive) and explore relationships with performance over a three year period: 2006/7–2008/9.

Clinicians on the board: the story so far

As noted, it is widely argued that increasing the participation of clinicians in more strategic leadership roles will have benefits for the quality and effectiveness of health services (King's Fund, 2012). In the UK this idea was central to Ara Darzi's review of NHS and the assertion that clinical leadership is necessary to transform services to achieve high levels of excellence (Department of Health, 2008). Linked to this have been attempts to create a 'mixed economy' of clinical and non-clinical senior managers in the NHS with doctors on the shortlist for all future Chief Executive Officer (CEO) appointments (Clarke, 2006, pp. 14–15). Similarly, in the US, Prybil (2006a, p. 22) notes how, as a strategy for improving the quality of hospital care the National Quality Forum and other bodies 'have urged boards to improve their communication with clinical leaders-physicians and nurses-and expand their involvement on boards'.

These assumptions about the positive consequences of clinical involvement in governance are also borne out by some research. This is notably true in the US, where, for some time, even public hospitals adopted corporate style governance arrangements (Kovner, 1990). Studies have found that boards with greater medical participation tend to be associated with increased engagement in quality improvement initiatives (Weiner, Shortell, & Alexander, 1997) and better informed strategic decisions more generally (Ford-Eickhoff, Plowman, & McDaniel, 2011; Goldstein & Ward, 2004). This research also suggests a link between the composition of hospital boards and performance outcomes. Focussing on seven high performing non-profit hospitals and a matched comparison group, Prybil (2006b) finds that the boards of former had engaged physicians in governance more extensively than had the midrange performers. Drawing on a survey of 490 hospital presidents/CEOs Jiang, Lockee, Bass, and Fraser (2009) also conclude that having a board quality committee with strong physician leadership can significantly enhance a hospital's performance. Most recently Goodall (2011), finds a positive association between the medical qualifications of CEOs and the higher ranking of hospitals.

Yet, while this research is promising a number of questions remain. *First* is exactly how much difference managers will make to performance outcomes? In the US, not all studies are equally supportive of the conclusion that greater board level participation of doctors will have positive consequences (Succi & Alexander, 1999). The more limited research on hospital governance in the UK and Europe also casts doubt on how much influence clinicians will have. Focussing on the boards of 22 health organisations in the NHS, Veronesi and Keasey (2011) for example, note how the effectiveness of clinical involvement is highly variable, especially where board discussions are dominated by financial priorities. A study by Addicott (2008) of five cancer network boards also queries the benefits of clinical representation, with some doctors adopting an advocacy role to promote the interests of their own speciality first and foremost.

These (and other) studies therefore raise questions about how far greater clinical participation in strategic decisions will improve performance. Much will depend on whether senior doctors and nurses chose to act opportunistically or as 'ambassadors', focussing on broader corporate priorities of service improvement (Hunter, 1992; Lister, 2000). A related question is the extent to which clinicians will be able to make their voices heard on boards? One might argue that their ability to influence decisions will be hampered not just by a lack of management training (Ham & Dickinson, 2008), but also by limited support and encouragement from non-clinical managers (Veronesi & Keasey, 2011). This is especially when the latter adopt what Edmonstone (2008, p. 296) describes as 'unitary' and 'command and control' viewpoint which 'denies the legitimacy for clinical leadership'.

A second question is whether the positive outcomes of clinical leadership derive from the participation of *all clinicians* in boards (including nurses and allied health professions) or only doctors? The latter follows from much of the sociological literature on health professions. This highlights the dominance of medicine and the ability of doctors, with substantial cultural capital, to influence decisions about diagnosis, treatment and the flow of resources (Harrison & Ahmad, 2000). On the other hand it might be argued that because nursing knowledge tends to be more population focused, 'systematized' and team-based (Degeling, Kennedy, & Hill, 2001), this will enable nurses to directly contribute to strategic decisions, especially when in partnership with doctors (Murphy, Quillinan, & Carolan, 2009; Prybil, 2006b).

Hence, while there are reasons to assume that clinical involvement in the strategic management will have implications for performance, a number of questions remain concerning: the degree to which this will occur and which clinician professionals are most influential.

Data and methodology

To address these questions our focus is on a particular national case: the NHS hospital sector in England. In 2008/9 this consisted of 169 acute care trusts, with a total budget (including community services) of £51.5 billion: approximately 64% of the total budget for front line services. Since the early 1990s hospitals (or in some cases, groups of hospitals) have been constituted as semi-autonomous 'trusts' with their own boards of directors, similar to private firms. Although formally part of the public sector, trusts are required (in theory at least) to secure contracts from primary care organisations that commission services from them. This has meant a much greater emphasis on improving the governance of health trusts with boards expected to take on key roles of formulating strategy, ensuring accountability and shaping culture (Healthcare Commission, 2009). Since 2003 an increasing number of trusts have also been re-designated as 'Foundation Trusts' with greater autonomy to manage their own affairs.

Because there is no central repository of information on NHS trust hospital governance the first step in our research was to construct a unique dataset by manually working through the websites and annual reports of individual trusts. Where possible we observed the composition of the board and, for all members, gathered information on their professional qualifications (for example, doctors, nurses, accountants, etc.) and job titles. Only trusts which offered full information in terms of the membership of their board in each year under investigation were taken into account, resulting in a final sample of 240 observation points from 2006/7 to 2008/9. Using this data we were able to capture changes in the board composition for each hospital trust and year