

Corporate management and clinical autonomy: The ethical dilemma in mental health

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Abstract

Funding constraints and management practices are increasing pressure on clinical autonomy within Australian mental health services. The introduction of total quality management, output-based funding and changes to public mental health policy have promoted business-like efficiency and increased control of resources. It is argued that such moves significantly circumscribe the discretionary authority that mental health professionals have previously enjoyed. This paper attempts to highlight the ethical and moral tension inherent within a corporate management approach, and calls for mental health services to acknowledge the value of intellectual capital, creativity and innovation.

The rise of economic rationalism and managerialism

Economic rationalist views have been widely adopted by governments and public administrators both in Australia and overseas over the past decade. Leaders of private industry encouraged governments to adopt their business aspirations, resulting in reduced payments for welfare and public infrastructure, turning the modern hospital into a 'corporate enterprise' (Galbraith 1992). Organised labour has been reduced to a small fraction of the workforce, both overseas and in Australia (Reich 1991), and this has been mirrored in hospital employment as well. Hospital management have increasingly emphasised greater efficiency of resource utilisation, adoption of new technology, the redefinition of professionals as employees, and patients as consumers (Stoeckle & Reiser 1992).

Provision of public funding for health services has been matched with an increasing focus on encouraging individual responsibility for health care, particularly through measures aimed at halting the dramatic decrease in private health insurance. Health services management have reinstituted goals once discredited, based on the ideology of managerialism – essentially a style of leadership reflecting the entrepreneurial values of the business community, and a user-pays philosophy (Rees 1991). After many years during which few changes occurred in medically dominated health management arrangements, there have been major changes, including a greater number of salaried doctors, increased financial accountability, and a greater degree of competitiveness between health care providers (Griner 1988; Feinglass & Salmon 1990).

Two contemporary hospital cultures now exist, the professional and the corporate, which differ in the values that underlie treatment and care (Stoeckle & Reiser 1992). The concept of treatment as a therapeutic responsibility to patients, reflecting the bioethical principle of beneficence, has been seriously questioned, and the previous assumption of professional autonomy as a prerequisite for quality of care is being replaced by peer review and implementation of additional supervisory mechanisms (Freidson 1994). In the United States this process has resulted in managed care administrators now prescribing practice standards to health care professionals.

Current trends in mental health

Mental health services, both private and public, are undergoing root and branch change un contemplated just five years ago. Management-driven changes have caused tension between the objectives of efficiency, effectiveness and autonomy, and are a special case of the wholesale changes now taking place throughout the wider Australian health care system. They may be summarised in the following ways.

Total quality management

Total quality management is a Japanese management philosophy focusing on quality, human resource management and statistical process control. It is aimed at improving quality and enhancing productivity in organisational and management processes and is now a major worldwide phenomenon, both in health services organisations and in other sectors of the economy (Osborn 1995). Since 1991, the Australian Council on Health Care Standards has encouraged quality management as a condition of accreditation. Quality service, customer satisfaction, and intensified

work practices that encourage staff 'to do more with less' may promote competition for scarce resources, and may lead to an increasing emphasis on financial management. Total quality management focuses managers on cost control, accountability and outcomes.

Output-based funding in psychiatric services

Australian mental health services have been generally funded using historical methods, an approach which Broadhead (1991, p 224) states '...tends to perpetuate existing services, [and] modes of treatment'. Funding practices in psychiatry are currently changing in response to demands for better evaluation of service efficiency and effectiveness. According to Faulkner, Tobin & Weir (1994), some State governments are currently considering the introduction of casemix payment funding, in particular the use of a diagnostic related group model for psychiatric illness. Arrangements of this kind could markedly restrict the discretionary authority of mental health professionals.

Public policy and mental health

According to Raphael (1996, p 3), comprehensive and integrated mental health services will '...be focused on consumer needs and outcomes, be evidence based and of the highest quality'. That is, service providers will often involve consumers in planning. Outcomes will then be defined and measured using formal assessments identified as relevant to consumers. 'Best practice' programs will be implemented and evaluated for their effectiveness in achieving desired outcomes.

These already existing change processes will also be influenced by overseas trends in managing psychiatric services. In the United States the terms 'managed care' and 'health maintenance organisations' are used to identify long-established methods of delivering health services through the introduction of purchaser-provider splits and third parties (Forde 1995). These developments created financial incentives to reduce the number of services and procedures, and increase efficiency and effectiveness. To the angry dismay of many American psychiatrists and other mental health professionals, however, decisions that were once largely their province must now be made in conjunction with commercial companies with whom providers contract (Iglehart 1996). That is, whilst behavioural health care companies have demonstrated a capacity to achieve substantial savings in managing American mental health services for employed people with private insurance, the impact of such companies on the role and autonomy of

psychiatrists has been substantial (Iglehart 1996). The issues of health maintenance organisations and purchaser–provider splits are currently being debated in Australian health services management, though they are yet to be implemented.

Typifying psychiatric labour markets

Mental health service provision is based on a number of differing and potentially conflicting assumptions which operate within fiscal and organisational frameworks. On the one hand, managers infer that mental health professionals can be motivated to change their behaviour by additional performance requirements to meet budgetary and resource utilisation objectives. On the other hand, managers presume that the responses of such professionals to financial incentives will be complemented by an ethical concern for the mentally ill to whom they provide their services, and a professional concern for doing good work – the ethical principle of beneficence. According to Freidson (1994), reliance on economic incentives is based on the actions of individuals freely making choices. Such freedom of action may not exist within formal organisational structures such as psychiatric inpatient units or community mental health centres.

In other words, doctors and other mental health professionals are engaged in a social system composed of colleagues in various collaborative or supervisory positions, and of administrators in other positions of organisational authority. There may be few universally agreed precepts to determine financial and organisational policy.

One way to conceptualise the organisation and financing of mental health services is to treat it as a labour market. Various classification systems have been proposed. According to Parkin (1991), there is the (privately financed) *free market* where workers compete freely to be chosen and paid by employers or clients and their insurance providers, with price and financial gain as prime motivations. Secondly, there is the *bureaucratic market* characterised by hierarchically organised and state-provided mental health services. Professional actions are constrained, the price of service takes second place to reliability of supply, and quality is defined by formal standards that guide the performance of workers. Consumer choice may be limited and workers compete for advancement through formal training and adherence to organisational rules. And thirdly, there is the *professional market* which is organised and controlled by the health occupation governing bodies themselves. Both employer and consumer choices are limited by such bodies, and emphasis is placed on ‘community’ and ‘collegiality’. Mental health services in Australia can be seen as a mix of the bureaucratic and

professional models, with elements of the former increasing in importance as the administrative structure surrounding clinical practice expands.

The impact on professional autonomy in mental health

It can be argued that the managerialist agenda has promoted the interest of the central and controlling levels of public sector bureaucracies, and constrained the influence of professionals with specific expertise (Yeatman 1990). Further, the concept of professional care may have lost its social meaning when viewed as a product (Holton 1964; Stoeckle & Reiser 1992), whilst technology and management of work conditions are designed to extract from the individual clinician maximum output (Rees 1991).

It follows that providers of mental health services no longer simply act as advocates for the patients: they must satisfy multiple masters – governments, health departments, solicitors, hospital administrators and consumer advocacy groups. Mental health authorities have (historically) operated with categorical program budgets (with strong emphasis on inpatient care) derived from an appropriation of public funds for the mentally ill. Now these authorities manage a complex array of services funded by a variety of federal, state, and sometimes local or transitional sources. According to Iglehart (1996), such corporate developments within mental health services have provoked unprecedented turmoil by eroding the autonomy of health care professionals.

Ethical parameters justified

The tension between clinical autonomy and corporate management may lead to a number of conflict scenarios. Examples of this effect include service development projects subject to transitional funding, or requests for additional staffing from clinicians in areas where existing resources are seen to be fully utilised (that is, the need for psychiatric intensive care nursing).

Such instances demonstrate that autonomous mental health professionals do not exist in the abstract, but are interwoven into social contexts. Downie, Fyfe & Tannahil (1990, p 138) argue that ‘...the ingredients of autonomy all carry an essential reference to society. Our self determination, self government, sense of responsibility, and self development are not only emotionally charged but also exist only in a social context and cannot really be understood without that dimension. The autonomous self is a social self’.

The role of professional ethics, in one respect, is to govern social function through moral discipline (Durkheim 1970). The role of clinical autonomy

therefore becomes important as a means of regulating future corporate directions in mental health services management, to ensure that the social consequences of managerial decision-making are not overlooked. It should contribute towards raising moral standards and assist in resolving contextual conflicts.

Clinical autonomy, efficiency and policy development

What strategic direction should management reforms take within mental health service provision? It is imperative to prevent the workforce from losing its professional commitment to ethical practice. We must ensure that measures designed to counteract professional abuse do not result in a morally and financially impoverished health system. Some areas where attention is needed if professionalism is to be advanced and the need for compensatory use of material incentives or bureaucratic control reduced are outlined below.

Forde (1995) argues that the Australian health care system is not structured by the free economic competition of all who wish to sell goods and services, and with consumers free to choose what they wish. Supplier-induced demand, ill-informed consumers who are unable to make free choices, occupational registration (preventing free entry into the labour market), and a complex and economically powerful administrative system that controls both demand and need for health care are some of the market failure characteristics in this respect. Policies that try to introduce material incentives and values connected with the free market model into a system that lacks the essential conditions for anything resembling a free market are likely to fail. In psychiatry, both patients and their significant others may not be in a position to be adequately informed, and therefore fully rational consumers who are capable of looking after their own interests in the medical market-place (Begun 1986). Indeed, it is for these reasons that consumer choice and access to psychiatric treatment is limited to registered professionals.

Freidson (1994) similarly suggests that bureaucratic and professional models are inherently hostile to each other. In support of this view, Granovetter (1985, p 491) argues that the bureaucratic model does not ‘...produce trust but instead is a functional substitute for it....substituting [bureaucratic] arrangements for trust results actually in a Hobbesian situation, in which any rational individual would be motivated to develop clever ways to evade them; it is then hard to imagine that everyday economic life [in the organisation] would not be poisoned by ever more ingenious attempts at deceit’.

Furthermore, the objective of the bureaucratic model is to control performance by formulating specific rules governing responsibilities and professional standards

to evaluate it. In attempts to reduce costs this way, discretionary activity has been reduced. However, mental health services are addressed to the central core of human existence – physical, spiritual and mental well-being, and the conditions of survival as a human being (Kneisl & Wilson 1986). According to Freidson (1994, p 193), ‘...the way one conceives of health care tasks and outcomes reflects the way one conceives of the people being treated [and] standardising the conception of tasks and outcomes for the purpose of measuring and controlling them also standardises the conception of people and their difficulties’. In essence, clients may be reduced to formally defined categories and become objects produced by reliable methods at reliable costs.

Saving professionalism from itself

Let us here indicate two areas that need additional attention if autonomy in mental health service provision is to be advanced and the need for material incentives or bureaucratic control reduced.

Peer assessment of quality care

Peer assessment is an essential aspect of mental health services quality assurance as currently practised in Australia. Almost all quality activity methods use peer review to make the final determination of quality of care, in medicine, nursing and allied health. The Australian Council on Healthcare Standards, for example, suggests that peer review be performed whenever the care by specific practitioners needs to be examined (1996). Others have emphasised that the effectiveness of peer review activities may be the crucial factor in determining whether or not health professionals maintain control over their respective professions (Reed & Evans 1987). If professionalism is to advance, it is essential that practitioners’ decisions be open to inspection and evaluation, and that results be made public. Mental health professionals, as opposed to those in other areas of science and academic scholarship, perhaps tend to hold differing conceptions of autonomous clinical judgement that leads them to resent examination, evaluation and commentary on their work. The climate of practice and review throughout mental health service facilities must change to accommodate such openness.

Industrial issues

Within both mental health and the Australian health care system in general, the formal organisation of work has changed in important ways.

Many more psychiatrists are now employed on salaries, and at the same time are faced with significant change in the industrial relations system with the dismantling of the centralised wage fixation system, that is, the implementation of enterprise bargaining (Power 1993). To date, the enterprise bargaining principle and other changes to the Industrial Relations Act have had only marginal impact on the Australian health industry. However, attention needs to be paid to these issues to avoid circumstances in which practice patterns are inappropriately influenced by organised economic pressures and bureaucratic constraints.

In the post-industrial era, the success of an organisation is widely perceived to depend on its intellectual and systems capacities, more so than on its physical assets. According to Quinn, Anderson & Finkelstein (1996), many successful private enterprises have abandoned hierarchical structures and organised themselves in patterns specifically targeted at the particular way their professional intellect creates value. Such re-organisation involves breaking away from traditional thinking about the role of the centre as the directing force. Professionals in the field then become the directing force and management subsequently adopts a supportive role. To this end, one can argue that the capacity to manage and make the most of human intellect is fast becoming a critical executive skill – yet surprisingly little attention has been given to managing professional intellect within Australian mental health services.

Conclusion

The rise of economic rationalism and managerialist ideology has forced mental health service providers to emphasise growth and efficiency, technology, professionals as employees, and patients as consumers. The managerialist agenda may have promoted the interest of the central and controlling levels of public sector bureaucracies, and constrained the influence of professionals with specific expertise. Professional care may lose its social meaning when viewed as a product.

The options for change that promote a combination of professional and administrative cultures include the promotion of clinical autonomy, supplemented by the enforcement of bureaucratic standards. Scope for success implies that ethics conventionally associated with mental health practice will prevent dishonest practice. Without public policy designed to strengthen professionalism, the social environment that sustains such ethics is likely to be damaged. The goal should be to promote commitment to quality care for the

benefit of the mentally ill by considering cost and reliability factors, advanced by effective modes of peer discipline.

Acknowledgements

The authors acknowledge the comments provided by Dr Margaret Tobin on an earlier version of this manuscript.

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