The ideology of 'accountability'

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Accountability and medicine

Over the past year the editor of the *BMJ* has described our era as 'the age of increased accountability'[1], and has suggested its worth for issues as diverse as journal authorship, conflict of interest, professional regulation, medical ethics, and New Labour. This exemplifies how the concept of accountability has become ubiquitous in political and managerial discourse over recent years.

It is my purpose to challenge the assumption that 'increased accountability' is self-evidently a desirable goal. Instead, I will propose that the meaning behind the accountability mantra is the opposite to that implied by its democratic, egalitarian, radical and 'empowering' rhetoric. In practice, accountability operates as an excuse for managerial takeover of the clinical consultation.

An excuse for the top-down exercise of power

The term 'accountability' serves a key role in contemporary politics and management as a justification for increasing governmental and corporate power over individual people[2]. Control is exercised indirectly by means of audit instead of orders. The ideology of accountability provides a 'stalking horse' behind which hierarchical domination may covertly be extended into new areas such as the clinical relationship between doctor and patient, or other primary skilled activities such as occur in the classroom and the research laboratory.

Vaclav Havel has described ideology as 'a bridge of excuses' between the system and the individual[3]. He refers to the mutually convenient way in which referral to an abstract and usually ill-defined set of ideals can cloak the naked fact of domination on the one hand and the humiliating reality of submission on the other. By this interpretation, accountability is the ideology by which the management-led nature of the 'reformed' NHS[4] has been softened and made palatable to the newly subordinated clinicians. At the same time, clinicians are provided with a comfortable excuse for failing to resist these trends.

For example, recent proposals under which medical consultant salaries (in the form of 'merit awards') will be decided by committees dominated by managers instead of committees composed of doctors, have been successfully presented as a triumph of democratic 'accountability'. Medical opposition has apparently been neutralised. Yet, and without wishing to defend the previous system of merit awards, these 'reforms' are merely another example of the subordination of clinicians by the organisations that employ them.

Of course, all organisations must be run on lines of proper financial probity, and it is trivially obvious that the NHS must operate within its financial envelope. But it should be equally obvious that financial considerations cannot be allowed to dictate the fundamental nature of health services – especially not the specifics of clinical care. The reasonable solution is that clinicians are constrained to deploy resources within broad general constraints, but are free to determine the specifics of clinical practice within that framework. In an important sense, the clinical consultation is the primary activity of medicine, and its autonomy should be the basic principle around which the rest of the health service is organised[4].

Accountability to whom?

If the increased managerial domination of clinical practice is an unacceptable reality, then accountability can be seen as the latest excuse for disguising its advance. In the acquisitive 1980s, the favourite excuse for extending managerial control was 'value for money', a rationalisation that proved to be utterly false. What evidence there is, suggests that managerial regulatory mechanisms cost a great deal more money than they save – in effect, they transfer resources from productive to unproductive areas[2,4,5]. Nowadays, 'value for money' is out of fashion: the 'caring nineties' uses a different style of rhetoric. Accountability provides justification for exactly the same centralising and coercive political agenda as characterised the 1980s. *Plus ça change, plus c'est la même chose.*

However, the freedom and independence of doctors would be of little general interest outside medicine were it not for the fact that managerial control of individual doctors also implicitly constitutes control of individual patients. In their clinical practice, many doctors retain significant autonomy, exercising independent judgment over matters such as time-allocation, prescribing and referral – this judgement being formed (to a significant although widely varying degree) in consultation with the patient. It is in this sense that the clinical independence of doctors also encompasses the independence of patients. However, the autonomy of the doctor-patient consultation poses a serious threat to political and managerial control[2]. Attempts to override autonomy need to be disguised, and the threat to hierarchical control mechanisms is therefore restated in ideological terms as a 'lack of public accountability': this version of affairs is presented as a menace to

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the public at large. Freedom is packaged and presented as irresponsibility.

Media-fueled outrage at abuses by doctors is typically channeled into demands for 'increased accountability'[1]. The process of media-induced amplification of individual instances allows a disregard of the much more difficult question of whether the system infrastructure as a whole is functioning, because only systemic defects demand wholesale changes to the system[6]. After all, the many defects of democracy do not justify a dictatorship; democracy is flawed, but better than the alternative. The same applies to clinical autonomy compared with managerial regulation. It is a question of which is the best system overall and in practice: there is no such thing as a perfect system.

Public accountability would, no doubt, be a good thing, but that is not what is on offer. 'The public' in theory always seems to mean 'officials' in practice. The solutions proposed serve only the interests of those who wish to subordinate clinical judgment to organisational regulation.

Managerial control of doctors and patients

The most fashionable method of managerial control is to impose a comprehensive audit system such as 'total quality management' or one of its variants containing the magic 'quality' word[2]. This is a subtle strategy, because the control is indirect and implied. Instead of a manager telling a subordinate what to do, the manager informs the subordinate that certain specific aspects of his/her performance will be audited, and that his/her salary, status and security will depend upon the outcome[7]. This is why protocol-based practice has received such vast official patronage: protocols, guidelines, standards (whether 'evidence-based' or not) can extend political control of health service activities[8].

Managerial regulatory systems are being wheeled forward behind the smokescreen of 'public accountability'. By a clever rhetorical move, a doctor's lack of accountability has been conflated with an attitude of arbitrary irresponsibility. But a doctor's responsibility to a patient is an utterly different thing from a doctor's 'accountability' to a manager: the former is ethical and legal, the latter contractual and regulatory. The public cares deeply about a doctor's responsibility to a patient, but not at all about a doctor's 'accountability' to a manager. Indeed, if the facts are presented clearly, most patients would prefer that their doctors were *less* influenced by managerial dictates, rather than being increasingly subordinated to organisational goals.

The wrong solution to the right problem: lessons of the 'Bristol affair'

The 'accountability' mantra has tapped into a genuine area of public outrage. Idleness, incompetence and dishonesty among doctors are significant problems, even though they are rare. These problems are untouched by a decade and a half of self-styled NHS 'reforms' that have diverted a massive proportion of NHS resources into managerial expansion, often under the guise of abuse-prevention and 'patient power'[4].

The clearest recent example in which a media scandal has been used as a 'stalking horse' to push forward a pre-existing managerial agenda is the Bristol affair, in which inadequate levels of clinical competence were judged to have led to an unacceptably high level of complications and mortality[1,9]. The events in Bristol have consistently been misrepresented as a failure to detect clinical incompetence, and hence a justification for introducing a vast, expensive and intrusive system of monitoring and regulating clinical activity across the board. But the lesson of Bristol is quite the opposite: it was clearly a failure of action, not of detection[9]. The Bristol affair demonstrated how easy it has become for politicians and the NHS hierarchy to manipulate the climate of opinion and disguise the implementation of an unpopular and ethically dubious agenda. The legitimate outrage against malpractice was used as an excuse to roll forward another system of audit-based regulation, and expand managerial influence over clinical practice without clinical responsibility. Meanwhile, the real problems remain unaddressed.

The public is entitled to expect protection from incompetent doctors and doctors who abuse their privileges. The present system does not provide adequate protection: it is very effective at detecting abuses, but when informal mechanisms at solving the problem fail, there are significant procedural obstacles to effective mandatory action in solving the problem[10]. But the answer to cases of egregious abuses is not a particularly difficult one and it carries no implications for changing the whole way in which medicine is practised.

Doctors' jobs are excessively protected, in a manner that is unjust by comparison with less privileged workers, and most importantly, they are protected even when it is at the expense of patients' safety[4]. It currently costs some hundreds of thousands of pounds and several years to sack even clearly idle, incompetent or immoral consultants who are not doing their jobs, and the situation is similar for general practitioners. The balance needs to be shifted decisively. Disciplinary procedures should be made swifter and cheaper, and based on the principle of public protection.

The way forward?

The word accountability originally meant having the duty to present auditable accounts[2], and, in a sense, that is exactly what it still means underneath all the cuddly rhetoric. Accountancy is an unlikely source for ideas about how to organise health services in an ethical and effective manner. In this respect, it is significant that the accountancy and audit-based model of the NHS has arisen alongside the expansion of private health care. Presumably those who promote the organisational accountability of doctors in clinical practice envisage themselves opting out of the NHS,

since informed and rational individuals could not possibly want managerially controlled health care for themselves.

There is no point in merely complaining: it is time for action. The managerial takeover of medical practice has been operating for many years, and conventional methods of opposition have apparently been powerless to prevent it. Intellectual arguments are conclusively against managerial takeover, but have little effect. As a result, both doctors and patients are despondent and resistance has collapsed, and things get worse even faster. People feel out of touch with, and unable to influence, clinical services, and government sponsored public relations exercises such as the *Patients' Charter* are immediately perceived to be yet another layer of bureaucracy imposed between patient and doctor.

My suggestion is that the way ahead lies in building a new alliance between doctors and patients, a whole new set of participatory structures from the 'grassroots' based upon face-to-face organisations that unite the interests of individual doctors and their individual patients at every possible level. Direct participation has tremendous legitimacy, and would inevitably exert a powerful upward pressure on existing forms of organisation.

My hunch is that that doctor-patient co-operation in pursuit of reform is exactly what politicians and managers do *not* want, since no opportunity is lost in trying to drive a wedge between the two groups. Yet the fact is that doctors' and patients' interests overlap to a far greater extent than the interests of either group overlap either with government or the NHS hierarchy and its officials. In particular, doctors and patients are united by a real, direct and personal stake in the nature and standard of clinical services.

A radical shift in the attitude of doctors is probably required before they can recognise and act upon the fact that – in the long term – patients (and potential patients) are their only solid allies in preserving the standard of clinical services. Of course, mobilising 'patient power' will inevitably also mean that doctors lose some influence in some areas, but even the cynical and self-centred may recognise that this is probably the best attainable strategic alliance. My hope is that we will see the growth of a bottom-up movement in which doctors and patients form a coalition to promote standards of clinical practice.

The clinical interaction between doctors and patients is the place where real medicine happens, and that is where the most significant power should lie. If push came to shove, the health service could manage without managers.

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References

1 Smith R. All changed, changed utterly. *Br Med J* 1998;**316**:1917–8.
2 Power M. *The audit society*. Oxford: Oxford University press, 1997.
3 Havel V. The power of the powerless. *Open letters*. London: Faber, 1991.
4 Charlton BG. Infostat, cargo-cult science and the policy sausage-machine: a critique of rationalist management in the reformed National Health Service. In: Miles A, Bentley P (eds). *Effectiveness and efficiency in clinical care*. Abingdon: Radcliffe Press, 1999.
5 Jenkins S. *Accountable to none: the Tory nationalisation of Britain*. London: Hamish Hamilton, 1995.
6 Willis J. *The paradox of progress*. Abingdon: Radcliffe Press, 1995.
7 Charlton BG. Essay review of *The audit society* by Michael Power. *J Eval Clin Pract* 1998;**4**:249–53.
8 Charlton BG, Miles A. The rise and fall of EBM. *QJM* 1998;**91**:371–4.
9 Willis J. The aftermath of the Bristol case: Case arose through a failure of action, not of detection. *Br Med J* 1998;**317**:811.
10 Donaldson LJ. Doctors with problems in an NHS workforce. *Br Med J* 1994;**308**:1277–82.

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