# Bringing two worlds together: personal and management development in the Health Service

Helen Jones interviewed by Devi Jankowicz

As the Director of the Centre for Leadership Development in the University of York's Department of Health Studies, **Helen Jones** manages a range of programmes aimed at senior managers and consultants in the National Health Service (NHS). The programmes draw substantially on a unique approach to personal, management and organisational development that she pioneered while in her previous position in a nearby Regional Health Authority.

**Devi Jankowicz** is Reader in Management at the University of Teesside.

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## Introduction

Helen Jones was appointed as a Regional Health Authority's Management Development Advisor shortly after the reorganisation of the NHS following the publication of the Griffiths Report in 1983. The NHS, Europe's largest employer with over 1 million people on its payroll, costing over £20,000 million per year, was changed in many ways during the ensuing decade, perhaps the most significant being the appointment of general managers with personal responsibility for the management of budgets in a time of escalating health-care costs, in place of a team-led approach. Fundamental differences in value systems– between organisational governance on the one hand, and personal care on the other; between financial control and medical/technical expertise; between loyalty to the employer and loyalty to a profession– were highlighted thereby.

> A major part of a general manager's job is to resolve the conflict between the dominant values of caring and efficiency and not to represent only the efficiency value... The NHS is very much a colleague culture where co-operation, particularly of the powerful (medical) professionals, has to be won. Allen & Lupton (1988).

In taking up her post, after previous positions as psychotherapist, counsellor, and O.D. specialist with the National Coal Board and British Airways, Helen's brief in this complex situation was 'to introduce hospital consultants to management principles: that was the task'.

Devi Jankowicz: I can see that you would want to coordinate the work of the various functional specialists, in introducing a general management role; why was it important to involve the consultants?

Helen Jones: Well, general management could not work without engaging the doctors' interest. At the time, Griffiths thought that doctors should be running the Health Service as general managers, alongside managers, because they used most of the resources; they were, apparently, accountable only to themselves and to the specialty which was their own particular focus; and the NHS was beginning to say that, 'since they're the ones who spend most of the money, we need to know how it's being spent, and we need to engage them in the whole business of management in the Health Service'. That is still an issue, but much, much less significant than it was ten years ago.

The first thing I noticed was that the Regional Health Authority was very rigidly run in Directorates: and people in Finance, and Estates, Public Health, Personnel, and others, kept themselves terribly separate from each other. And that was quite a surprise to me, because I was used to organisations where there weren't these boundaries. And particularly, people who worked with medical specialties at the Regional level within Hospitals kept themselves quite separate from the rest... interesting.

## A FOCUS ON INDIVIDUAL DEVELOPMENT

The first thing I did was to attend a training programme that was already being run, a traditional 5-day management training programme, which I quite enjoyed. I was working with a group of Senior Registrars. But I felt very strongly that people were being offered a lot of tools and techniques that didn't have much context; that they weren't being included as individuals; and that 5 days is a kind of 'sheep-dip' type treatment, and doesn't effect great change. Sometimes it's quite fun, but it doesn't do an awful lot about actually helping people engage with an organisation later on.

So I felt then that I needed to do some research, to find out much more effectively, in advance of a programme, what people felt and thought, what their values were, what they would and wouldn't want in development programmes.

Because they could really turn on the trainers, instantly, if they felt they weren't up to it. The trainers we had at that time were competent, but they weren't up to a great deal of challenge; and doctors are very bright, and if they see a weakness in an argument they'll bash in there and cut you off.

I felt there was a lot of unconstructive conflict between the group and the trainers, and there didn't seem to be any sense of moving from the inside out. So I was rather critical, really.

DJ: Just a passing thought, really. You know, the 5-day course, conventional, bit of a 'sheep-dip'... it's quite a long, and deep, 'sheep-dip'...

HJ: It is! So it should be good!

DJ: There is so-called 'management training' which lasts a day or two days...

HJ: Yes, that's right.

DJ: ... you were saying that even 5 days wasn't sufficient, because you felt that to get anywhere, in training consultants as general managers, you had to involve that personal element, yes?

HJ: Yes, absolutely.

DJ: Why was that?

HJ: Well, because if you don't engage peoples' hearts and minds, change is usually very superficial, and you can teach people a few techniques, but...

I suppose that there was a sense of mission with me, that if you're going to involve people with a major change of identity, which moving into general management would be for consultants, you have to take them as whole people, and you have to take seriously what's happening to them.

I guess I'm a bit 'heavyweight' about my approach to development; I really don't like the quick and superficial. It can be very effective, and if you're learning techniques, it's fine. But I also think that if you do it for 5 days at a stretch, and you then carry on with the rest of your life, the impact can be minimal. And it's a lot of money to spend, a five day residential programme, if you're not going to effect very much change.

DJ: I'm picking up on that word 'change of identity'. You saw some kind of change in 'who *I* am, if I am being asked partly to step into a different role...'

HJ: If someone has had twenty years or so being trained as a specialist to focus more and more and more intensely on one area of work (maybe, one part of the gut) as opposed to managing an organisation with all the fuzziness and messiness that goes with that... You're actually meeting people who've lost touch, very often, with whole aspects of their personalities. And it's quite a shock for them to move from being expert to being ignorant; and inexpert; and full of mistakes.

My training programme was designed to foster experiences which would allow them to explore those apparent 'failures', in a context where they weren't going to lose too much status by being seen to be not very good at things. So it was good from that point of view.

I talked to my boss, the Regional Training Manager at the time, and I asked 'who are the people I need to go and talk to, to get into an understanding of "doctors' culture"?' So I went to see a variety of people who were involved in doctors'... development, if you like. I went to see Regional Advisers in general practice, I went to see people in hospitals with responsibility for post-graduate medical education, and I just started talking to people. What I was looking for, really, was to get a sense of what it felt like in the organisations where these doctors worked.
So the first bit of 'woolly' research was to go around with a General Manager who was very helpful to me, really just getting to know organisations and 'catching them out in good practice'.

And we wanted to know particularly where doctors were involved. So we did a major survey of what the climate and context was like. And nine times out of ten the organisations would talk about their development work for people in the organisation (they called it 'training', then), and when you asked 'what about doctors?' they'd say 'Oh, doctors...'

They were being left out of organisational culture. And I began to get the sense of people who were quite isolated. Quite lonely, quite cut off in their specialist places; focused very much on patient care, and not having very much connection with the organisation. So that was useful information to start with.

DJ: Right. And, just as a side-issue, did they, from their own professional backgrounds, receive *any* developmental inputs, or was it always medical/ technical?

HJ: Very, very little. Mostly, continuing medical education. But this business of 'management for doctors' was in the air, and in the Yorkshire Region, the approach had been to give doctors extra study leave, if they would take part in these free programmes. Because in those days, Regions had lots of top-sliced money to spare, and it was being focused on doctors. And that was the money I had to manage, and that process.

So the major, major thing for me, I think, was going to meet a senior medical person, who had enormous influence over whether anything I did would have any impact or not. He could say 'yes, this is a good thing', or 'no, it's not', and I think that was the most difficult interview I had in my whole time there, really. Because he was quite a crusty character, very... strong-minded, very... Christian, and very judgemental. And very anti 'these young women', as he called us, (although I was probably older than he was!), who came along 'trying to turn my doctors into something else– when they should have their heads down, looking at their medical careers.' That was his stereotypical character.

DJ: But behind the stereotype... did he recognise the need for any change?

HJ: Behind the stereotype, he was a good example of how many doctors behaved in those days, and still do, to some extent. Which is that they might put up all sorts of difficulties in your way, just to see if you're up to dealing with it. Put you on your mettle, really, and if... if you fail– you're out. And if you pass that test, you're okay. And, fortunately, I passed it: but only because I stood up against him, on some sort of moral principle. That he was being, I thought, very judgemental, inappropriately, about somebody who was doing some of this work that I knew. And I just said that I thought it was quite inappropriate for him to judge that person– for things about her personal self– when in fact

what she did was extremely good, and I though he ought to keep those things separate. And I really took my... heart in both hands, I think, when I said that. I thought that if I don't stand up to this person, and say what I really believe, it'll fail anyway, so what am I going to lose?

But it actually turned it round. I mean he was always difficult after that, in terms of counting the cost and so on, but he became very engaged, and he also took part in the major research project that came a couple of years after that, when we had money to send doctors to business school, and I wanted that money to be spent well, by engaging them in a process of 'what are we here for, how do we repay the organisation and learn to work with managers?' He actually took part in all that, and he went to business school himself. And it changed him, really. I read something he wrote quite recently, in a journal called Yorkshire Medicine . They've just published their 10-year Anniversary edition, so he was recalling the influence he'd had on people at that time– which was quite good!

**THE CHANGE PROGRAMME**

DJ: Okay, so you were able to start. What happened next?

HJ: Well, we *had* started! But we did more, because of that. I mean, I started to develop programmes which I thought were more appropriate for people going through identity change.

Which was, first of all, to say that they should never last less than 6 months. And that they should be about application of theory into practice; and that whatever you did at the beginning, in a couple of days or three days as a residential, you would go back and apply; and you would come back together in Action Learning Sets, to reflect on progress, to support each other, to challenge each other's activities, and to learn and to develop each other, as opposed to *being taught*. This was quite a big change. We still did management-type exercises and so on, exploring learning experiences, but the major feature was the facilitated Learning Sets.

And the fact that it didn't take people very long to realise that what they were coming for was not *management* development, but *personal* development.

Doctors had very often been frozen at the age of eighteen, taking on more and more specialist training, and were less and less concerned about themselves. We created a kind of culture where it was all right to talk about yourself. You can do that with other colleagues but you cannot do that on the job because there is this expectation of never failing, always knowing the answer.

DJ: So far, you're describing something which characterises quite a lot of management development in which it's acknowledged that, in some way, the course participant needs to personalise, internalise: what was special about your own approach?

HJ: I was working very much from a background in Personal Construct Psychology (PCP; see the Table). You do not start with the group: you start off with the individual, regarding them as unique. PCP offers four very useful principles to O.D. practitioners. (Four amongst very many other useful ideas.)

**First of all, you listen to yourself.** And I did find that, at the time, the trainers that I worked with didn't do that very much, really. And it was something about your own understanding of the impact you have as a person on the people around you. You have to be very self-aware, and you have to be very self reflexive.

**Then, you need to listen to other people in almost the same way.** You have to listen to them in *their* terms, not making judgements, as I've been doing earlier in quoting some stereotypical views of doctors and so on, but looking at each one as separate, individual, unique, with their own set of values: which you don't know, until you listen properly. And you can't assume that you know– and an awful lot of assuming seemed to be going on– and you have ways, then, of checking out the implications of what they say. So that was demonstrated, sometimes through Laddering technique and other approaches within PCP which help you really to understand where the other person is coming from.

**And you also need to take huge responsibility.** When you were making an intervention of that kind, you're doing something pretty powerful. Those five-day courses, good bad or indifferent, are powerful, and longer programmes are *very* powerful, so you really need to know what you're doing, I think, and take some responsibility for that.

**I brought in an emphasis on reflection,** within the team, which– and I'm sure it is evident on any good training programme, nothing special about ours– but we began to make it a major focus.

And we also introduced the ideas from within PCP into the programme.

At the time, I was probably, rather naively, playing with a Repertory Grid programme, FLEXIGRID, which we brought in as a sort of evening activity for those people who might be interested because it was a computerised thing.

One or two of them liked that, and we introduced things like working with character sketches, as a way of reflecting on their learning during the programmes. And, for the groups where it felt appropriate, I would teach them something about the theory of PCP, and Laddering technique, and they did quite a bit of work with each other. Some of them found it not very interesting, others took to it like ducks to water.

Generally, though, I learned that to *teach* PCP on these programmes was not the way to introduce it. It was a matter of *using* it, rather than teaching it, that was important. So I learned quite a lot from that at the beginning.

DJ: Was there any difference in the kinds of people who did, or didn't find PCP useful?

HJ: Yes. I mean, psychiatrists liked it, on the whole. Pathologists, actually, did too. Surgeons were very 'clickety-click' in their replies; they tended to give extremely pre-emptive, bipolar responses when they were asked to specify their personal constructs, and treat the exercise as a 'psychological test', and more or less say 'so what?' at the end of it, looking for a cut-and-dried answer at the end of the process.

DJ: Was that still the reaction after you did the Laddering exercises, and got them talking about their personal values?

HJ: No, not on the whole. What *was* always very powerful was if I would do a demonstration Laddering in a group. And that worries me a bit, because it's a bit like playing 'magic tricks'. But, at the same time, it's a very powerful way of getting at deep personal values, and nearly always makes people think about their personal assumptions about their colleagues. Just one

demonstration very often has a powerful effect on the group in terms of how we and they listen to each other.

DJ: Just as an aside, you know, the more effective any psychological technique is... in other words, the more it fulfils the whole psychological mission 'to understand people and predict behaviour', the more it raises all sorts of issues about control, because it's suddenly... it's 'for real'.

HJ: That's right. That's right. So you had to time them, those kinds of interventions, very carefully, really.

DJ: Okay. So the way forward was not an account of PCP and the theory, valuable though it might be when people eventually get round to it.
So: what *was* effective? What did you in fact find yourself doing that was effective?

HJ: Well, I think, creating a climate in a number of these programmes– and we did them for Senior Registrars, newly-appointed consultants, GPs, practice managers, quite a lot of people (because there was quite a lot of money at that time). Soon, if I asked to introduce a new programme, which involved doctors in management, I got quite a lot of support.
So, I set a culture where there was longer-term training, where people came in as individuals, and the climate within the programme was to help them grow as individuals. I suppose I brought myself, and that's always a bit of a worry, because as I try and leave now, it is a problem. And that's the downside of being very self-reliant in the way you introduce things.

**EVALUATION RESEARCH AS PART OF THE CHANGE PROGRAMME**

And then I had this opportunity to apply for a large sum of money from the Department of Health for an evaluation study. There were quite crass ways of making change happen in those days. If they wanted to involve doctors in management, they just said, 'well, let's throw quite a lot of money at doctors, send them to business school, see what happens.' But we were well down the line of developing people as individuals by then, so we could use this opportunity to, as I wanted to at the time, stop doing 'doctor development' and start doing 'doctor and manager development', bringing them together.

I decided that the way to evaluate that process was to undertake a piece of research, when I would meet with every individual who was going to go on the change programme, doctors and their managers, (though the managers *weren't* going on the programmes at the time). I used PCP technique directly, in this research. Working with each individual, I'd agree a set of desirable outcomes in the programme, which became the elements for a basic Repertory Grid; elicit the individual's constructs about the desirable outcomes; Ladder all of the constructs to identify the personal values involved, followed by a Resistance to Change technique to identify the individual's personal value priorities. We'd then follow this up with a personal biography exercise.

So, I suppose I listened to hundreds of people's stories before they took part in these programmes, shortly after they completed the business school part of it, and then a year later, and although it was such interesting qualitative research and I didn't manage to publish very much as a result of it– the actual impact of it, in terms of the culture, in Yorkshire, was profound. (See e.g., Jones 1992; 1996.)

I think it was because this was the first time most of these people had ever sat down and thought in depth about themselves. Most of them found it valuable, got a lot of insights, and, I think, created– and this may be a good or a bad thing– created a relationship with me which meant that I knew a lot about them and they trusted me. This actually helped the networks that grew later; because even if people didn't know each other, I knew them, and brought them together, because we had various group meetings to deal with the data. We brought people together just to look at the raw data, the constructs and so on: to share the constructs and values people were using.

And there would be partly a social reason for that, partly the time to reflect on the process, and what was happening, how it was working, and partly to actually *play* with this data, to see what themes there were that were of interest about differences between doctors and managers, and similarities between doctors and managers. A paper exercise which actually confirmed what these people knew, but it was a very good way of bringing them together to discuss it. Half the day would be presentations of what people had done with their personal development programme, and how they'd applied it, and what they'd done at work, what differences...

There was a lot of sharing, and also sharing these interesting differences that emerged. Which, in the end, weren't so very different, as you wouldn't be

surprised to hear, really, since bottom-line personal values tend to sound very much the same. With doctors, it was particularly professionalism, commitment to patient care, and integrity.

And with managers... integrity was still there, though, in a sense, I think they had a more varied set of core values, because they were people on shorter-term contracts, from very different backgrounds. Some of them were in the business for... money; not many. Some were in the business because they wanted to do good; some were in the business because they'd just been brought up through the National Health Service.

There was a common denominator, which was quite a lot of dedication to the NHS, which brought them together a bit, and there *was* a feeling that doctors and managers were not all that different in terms of how they look at the world, but they're very different in terms of the way they get to where they are.

Doctors had quite strong, but narrow, views, and managers had a much more varied set of constructs. So, although I don't think there was any profound finding from the group work, certainly the individuals concerned became very much more aware of how they practiced and who they were as practitioners, and whatever it was they were doing, by being involved in the programme evaluation research, as a basic part *of* that development programme.

**DIFFERENT WAYS OF CONSTRUING, BUT SHARED PERSONAL VALUES**

DJ: I've got two questions floating around at the moment, as you can see from my expression.

There's something about ownership. In other words, here's a person saying, 'Well, look, this is me, this is what I am, and, it's actually quite similar, I can see the same in yourself'; that's one thing.

The other thing is the thought that the values themselves are somewhat similar– and yet earlier, we were talking about 'the divide' between medics and managers. Can you say a little bit about that?

HJ: Well, it's about perception, isn't it? There's a perception around, that managers are there to do one thing and doctors are there to do another; they have different kinds of educational background, and overall, the focus of management has to be general, an organisational focus, while the focus of doctors has tended to be specific about their specialist areas. But I guess that the fact that they'd all been through these interviews, and they'd ended up saying things that were similar about *why* they did what they did, it's subtly powerful.

I don't know what... I'm always surprised we should think that we are so very different; how our clubs and elite groups and specialist learning teach us to say 'We're very different from you'.

DJ: Maybe we behave in disparate ways because we're drawing on rather distinct and different *peripheral* constructs, as it were, which are relating to the job at hand...

HJ: ... which are highly vocalised ones, right...

DJ: ... the domain at hand, and it takes something like a Laddering exercise to realise that, yes, of course they're different, but they seem to reflect the same, personal, *core* values.

HJ: Yes, I think that's right. I think it was the actual process of having taken part in those repertory grid conversations with me, which they all did– there was only one person who didn't manage to complete an interview, quite willingly and happily, really, and that was because he'd recently had a bereavement which made it impossible for him to cope with it, so we didn't continue– but everybody else just seemed to find it very fascinating.

And I suppose I realised that the NHS is a culture of care about *people*, but not much care about the individual staff workers, and this was a way of actually exploring that. It's much more common now, in the Health Service, I think, for people to have personal time, mentors, and personal development and career development, it's happened over the last ten years really; so I was doing what was in the air, anyway, and has been developed since.

DJ: Earlier on, just a few moments ago, you said 'Everyone.' Just, factually, how many people did you end up working with?

HJ: Quite a lot, really. I guess that, in depth, in that way, there would be about three hundred; but overall, on the programmes– because I couldn't go on doing that sort of in-depth work for ever, it's impossible, it took my whole life up, and I needed to do other things!– it would be about a thousand people over the last seven or eight years.

And the sort of principles I used, now run through all the programmes which I am currently leading. The facilitators who work with me became interested, and I ran, and do run, a number of programmes of introduction to Personal Construct Psychology, with the associated methodology. So most people have been through some sort of training, to a basic level.

## CURRENT PROGRAMMES FOR MANAGERS AND DOCTORS

DJ: So, in terms of continuing development programmes, that bring together medics and managers, or medics as managers, and so on, to what extent has that in-depth approach made an impact on the programmes as they're offered now?

HJ: I think it does... it's not... there isn't the money around; there isn't the one-to-one possibility that there was, during that period. But currently, each programme is built on those principles.

Each programme (usually for up to a hundred people at a time) runs over several months. The group come together at the beginning and we start with a... with almost a blank sheet of paper. We have a structure that we know works, but the actual content, and the process, is from the actual people in it; they emerge from the way we run the programme.

And we do things, like... we always have a residential at the beginning, if we possibly can, which gives people time to risk a bit of personal conversation.

We often start with– well, I often start with, and I know that a lot of the others do– the principle that you write your own book during these programmes. We give everybody empty notebooks– nice coloured covers and so on– a blank book that will be written through the programme.

DJ: What sort of thing goes into that?

HJ: Well, the first exercise I often do is like this.

'Before we even start. Can you think of three things; one is "something that was very important to you during your growing-up period", the second is "something that you think is a significant achievement", and the third, "something that you aspire to" '. (Which are sort of Personal Construct Psychology-ish things, but we don't label it as 'PCP'.)

We simply ask people to introduce themselves to each other from one or another of those perspectives. And its quite amazing how doing just that, on the first day, gets people beyond the surface. Instead of saying, 'I'm so-and-so, from so-and-so', which we do, we then say, you know, 'I'm so-and-so from so-and-so, and this has been important to me in the past', or 'this is important to me now, and this is what I'm hoping for'.

DJ: So, putting that bit in the book is a personal resource...

HJ: That's right; and it's a starting place for everything else that we do, and it gets people into this mode of saying that *they* are central; how they reflect and see things is really important. Keeping that going takes quite a lot of skill. People rush back to 'task' very quickly, and it takes a lot of skilled facilitation to get that balance of acquiring knowledge, and skills, and practice, and awareness of Health Service changes; and recognising that you have an awful lot more power if you reflect on yourself and the way that you do things.

**PERSONAL DEVELOPMENT AND MANAGEMENT DEVELOPMENT**

DJ: I'm interested in that relationship that you raise, between process of self, / process around self, and task. Is it possible to say a little about... Yes, I can see the enormous value in PCP, and in the exploration of myself and how I bring my values to bear on what I'm doing. Fine. Alongside that, the label put on the course, by the person who has funded it, is '*Management* Development'! How do you bring together the exploration of self with the purpose, in somebody's head, of making managers out of consultants?

HJ: Well, I think it's moved beyond that, because that research process that I involve people in, involved managers as well. Some of them are chief executives now. They were involved, and realised, many of them though not all, that you have to be aware of your own processes if you are a leader of an

organisation, or you can't function too well; and they also know that you can't engage doctors unless they are engaged personally in something like that. And that they can't manage doctors unless they are engaged personally.

So what I saw it as, was, firstly, a development of awareness of relationship with yourself; and secondly, a development of relationships as human beings between managers and doctors. So that, once you have a personal relationship, you're going to work together very differently. That's the '*management* development' part.

Nowadays, when chief executives have to sponsor doctors to go on programmes, money is not easy. What do I do? I suppose I'm... well, what I do now– because I've won quite a lot of tenders over the last couple of years, for the university– is write all this into the tender proposal, and make sure that the unique, personal side of things is very much emphasised as part of the way we do things.

And our emphasis now is on bringing together those two sorts of culture so that we can work together within this health marketplace– and certainly our end of the process is in facilitating the process, and their end of it is bringing in the task knowledge and skills expertise. And it's very interesting how we are learning those relationships with each other. Quite difficult, actually; it's like putting us, providers and clients, into the position of the doctors and the managers, really, of recognising our differences and trying to build them into strengths, rather than competing. You've got to be very political.

**RHETORIC AND POLITICS IN DEVELOPMENT**

DJ: But back to the issue of developing doctors into managers. I mean... the naive question, I'd like to spell it out. How does taking part in a process which encourages me to think, systematically, about my constructs and values; how does getting me to sit, politely and with increasing interest, listening to someone else doing the same– how does that make me a better manager? (I've said that it was a naive question, but... )

HJ: It's a very good question, really. Let me think about it. What *I* think managers are, and should be– and it may be not what other people think– I think that they are people who *enable*. And if enablers are not aware, like psychotherapists, counsellors, other people, of their own processes, they're

going to enable in rather thin, narrow, possibly prejudiced ways. Certainly, that's what I found.

I found this 'big' view: 'Doctors are difficult', quote, that was what I met when I started. And it seemed to me that if you could make doctors... not 'difficult', but 'human': that would enable managers to work with them better.

I mean, you get, frequently, I'm sure you know, hugely stereotypical views between nurses and doctors, and particularly nurse managers and doctors, and vice-versa. But doctors don't have too many axes to grind because they know they're well-off, high-status, they've got very little possibility of losing their jobs, or had; and their lives are much more secure in a sense. At the same time they're much more risky, because they do the direct patient 'care or kill', and that's high-risk. And they need to be *enabled* to do that.

But a lot of management processes seem to be focused on controlling, and structure, and things like that; and there was a lot of that going on in the Health Service: 'we must control our doctors'. And a number of managers were inventing processes and structures that would put doctors in a more junior position so that they *could* control them. Forgetting the politics that underlies all of that; and that the more you encage people, the less likely you are to engage their real goodwill and expertise.

Here's an example. One or two people have written about the time when contracting came in to the NHS, and how doctors got left out of the process. That was the biggest challenge during the immediate reform period I think, when huge status was, sort of, imposed on managers, giving them a lot of power and control over areas in which they were then perceived as ignorant.

DJ: Yes; after 90 NHS administrators were promoted into managerial positions, the Ministry insisted that 'new blood' be brought in, and 93 general managers were appointed from business, commerce, the armed forces, and the public sector (Allen & Lupton, 1988).

HJ: It must have been 1991/92, that period, when the whole business ethos moved into the Health Service in a big way. Management moved away from general management, into a *real* power issue. Where you would find a Board with a Medical Director: but the Medical Director's role would not be necessarily to advise on medical matters, but to control discipline and corporate behaviour. And doctors were being clearly seen to be left out of the contracting process.

Things being done 'on their behalf' in a way which was, in their perception, not appropriate to patient care. I think that's shifting again now.

And it was ridiculous, actually, that... I'm thinking of an example of a consultant psychiatrist who's been involved in one of the programmes, who is responsible for a huge section of the country in terms of Sections, and this sort of thing, not having any contribution whatever to the mental health contracting process– quite extraordinary. Quite extraordinary. So that managers would see themselves as looking after the 'housekeeping' of the whole, but sometimes forgetting that, without the professional expertise, you can't make the decisions.

DJ: And that would be the sort of thing that they would hammer out in your groups?

HJ: Absolutely. Absolutely– and working together on it, actually in itself dissolved a lot of those tensions, and raised the level of the argument...
Nowadays, in running their organisations there are managers who will say 'the majority of resources are used by our doctors, so if we do not engage our doctors in the deployment of those resources, we are wrong.' And there's a Trust fairly near you, where I'm really, really impressed with the structure that was brought in to manage these differences, which is that doctors are responsible, have to be given responsibility, have to be given budgetary control, and have to be given management support. And the line between Chief Executive and those people leading clinical services is direct.

Whereas in the places where they want to control doctors, and push them down the organisation, there would be 'vertical' systems where the principles of Elliott Jaques and Warren Kingston's work (the Brunel structures), were instituted firmly, puting doctors down in Level 3 and Level 2 with no strategic input whatsoever.

DJ: Yes. You remind me of a phrase that Bob Garratt used in a book aimed at company Directors (Garratt, 1987) which was, you know, 'you have a choice: continuing to keep the lid on organisations; or put in the systems which...'

HJ: '..encourage...'

DJ: ' ...*make* organisations self-adaptive.'

HJ: Absolutely.

DJ: Yes. And the reason for going from the first to the second is cost: it just gets so expensive to keep the lid down.

HJ: Absolutely. And you lose the human potential that is there. I think that's right. I mean, we've used learning-organisational principles throughout this work, and PCP isn't the only thing. PCP with Action Learning based on Revans' work (Revans, 1982); ideas from the work on the 'Learning Company' by Pedler, Burgoyne and Boydell (1991) seem to marry very well. There are lots of commonalities between them.

DJ: Yes. That's all from me, Helen, that I wanted to cover. Was there anything from yourself that you'd like to emphasise? I mean, at the beginning you said 'this is going back over, I've moved on'.

HJ: Yes, I've moved on, yes. I suppose that it's another story, really; what's happened to me during those processes, was... actually, it probably *is* worth saying. I suppose my great advantage years ago, although it was also difficult, was that I could be immensely credulous. I knew nothing; and I could really practice that 'naive listening' which PCP helps you to do so well.

As I've been more successful, and people know me better, I've been put much more into the foreground, and I've had to lead political changes, and be the upfront leader, leaving other people to do the interesting, credulous work, because I've had actually to run the show.
And I want to move on from there. I am ready to become naive again, do something different. I prefer being in the background to the foreground; and yet that's not how I'm perceived anymore.

DJ: So: time to move on, yes.

HJ: Time to move into the background, yes, I think so.

DJ: Helen, thank you.

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**Table**

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| Personal Construct Psychology | asserts that the way in which people explain the world to themselves is epistemologically identical to the way in which Science builds theories *. The theories they build are personal; so, to collaborate effectively with another person, you have to understand their theory– in their terms, not yours. |
| Repertory Grid | a technique for identifying personal constructs: the basic constituents of a personal theory, which specify the terms a person uses. |
| Laddering | a powerful technique for identifying a person's values |
| Resistance to Change technique | identifies the way in which a person prioritises his/her personal values. |
| * assuming you accept that 'scientific method' is at bottom constructivist rather than positivist; no more than a social consensus between scientists about those parts of their personal theories that apply to their chosen discipline. This view upsets many positivists, but seems an excellent basis on which to build understanding between previously disparate groups of people. **D.J.** | |

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