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# Polish and UK doctors' engagement with hospital management

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**Polish and UK doctors' engagement with hospital management**

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## "Polish and UK doctors' engagement with hospital management"

*Keywords: health systems, market reform, doctors, medical manager roles, engagement*

### Abstract

**Purpose:** This paper compares the way in which two health systems with distinct histories, the UK and Poland, have altered in recent years. It focuses on the way in which these changes may be impacting on hospital doctors' engagement with management in each country, and whether there are any signs of convergence.

**Methodology:** A framework for the comparison of medical management roles, developed by Kirkpatrick et al (2012) was adopted, with a thorough but focused review of the medical management literature, together with analysis of policy documents and healthcare statistics conducted (Charmaz, 2006). The study collected some much needed primary data from expert informants within Poland and also drew on other interviews conducted with postgraduate level doctors in the UK over the same time frame, the first half of 2010. A theoretical sampling strategy was used in each case (Gomm, 2008).

**Findings:** The research suggests that doctors' engagement with management in both countries is changing, but for different reasons. In the UK, it appears that the duration of public management reforms and recent support for management involvement at academy level may be increasing engagement, whereas in Poland new structural arrangements appear to be decreasing doctors' engagement.

**Research implications:** The paper highlights recent changes in doctors' engagement with management in both systems, and considers possible explanations for this along with implications for the profession in each country. It also offers avenues for future research.

## Introduction

European health systems have undergone considerable change in recent decades, in terms of the way in which they fund, provide and govern services (Smith et al, 2012). Mechanic and Roquefort (1996) argued that whilst health systems are converging in their responses to similar technological, economic, demographic and scientific challenges, this does not mean that they will not exhibit differences due to their individual historical political and social characteristics. Others support this, finding differences between countries, based on their historical arrangements and the way in which professional groups respond to change (Sehested, 2002; Kuhlmann et al, 2009; Leicht et al, 2009). The role that doctors, as a dominant professional group, play in relation to the management of health systems has been a source of great interest across nations (Dent, 2003; Jacobs, 2005; Kirkpatrick et al, 2011; Saario, 2012).

This study sought to compare the way in which doctors engage with management in two countries with very different backgrounds, Poland and the UK. While the UK has attracted previous academic interest, Poland has received surprisingly little attention within the public management literature. The two countries are interesting to compare, given that the UK is a 'neo-liberal welfare regime' (Dent, 2003; Kirkpatrick et al, 2005), and one of the early adopters of new public management reforms and practices that emerged in the late 1970s (Hood, 1991), whereas Poland is an ex-socialist/communist regime which bears traits of both the neo-liberal UK and corporatist-German models of health provision (Dent, 2003; Sagan et al, 2011).

The paper is structured as follows. Firstly, our methodology is outlined. The paper then provides an overview of the two health systems, in terms of the ways in which they were funded and governed in the immediate post war period, the reforms that have taken place and how they currently compare. Our findings on the way in which doctors engage with management within each health system and how this is changing are then

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3 discussed. Possible explanations for, and implications of, the changes are discussed,  
4 along with opportunities for future research.  
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## 8 9 **1. Methodology**

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11 A framework developed by Kirkpatrick et al (2012) was utilised to help structure our  
12 work. This suggests that a number of potential factors might have impact on the  
13 development of medical manager roles: (i) the structure, funding and expenditure on  
14 health (ii) the organisation, training and contractual arrangements of doctors and (iii)  
15 the management roles taken by doctors in each country. The research drew on both  
16 primary and secondary data sources from the healthcare management, policy and  
17 sociology of the professions literature. Firstly, a thorough but focused review of the  
18 literature on medical manager roles was conducted (Charmaz, 2006), via a search for  
19 relevant articles and initially reading through abstracts on the following databases: ABI  
20 Global, EBSCO Business Source Premier and Medline. Secondly, Organisation for  
21 Economic Cooperation and Development (OECD) health statistics were reviewed and  
22 policy documents analysed. Thirdly, we collected exploratory data during the first part  
23 of 2010 from expert informants within the Polish system. These included a manager of a  
24 public hospital, a CEO of a private hospital, the President of a provincial board of the  
25 Polish Chamber of Physicians and Dentists, a former Vice-Rector of a University Medical  
26 College and the President of a Polish Association of non-public hospitals. We also drew  
27 on interviews being conducted in the UK alongside this study with 22 postgraduate  
28 level doctors, to highlight signs of attitudinal change towards engagement with  
29 management in the UK context. A theoretical sampling strategy (Gomm, 2008) was used  
30 in each case, with semi-structured interviews (King and Horrocks, 2010) conducted  
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## 51 **2. The UK and Polish Health Systems**

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54 The UK National Health Service (NHS) came into effect in 1948. It continues to be based  
55 on the original Beveridge model of a publically funded (via taxation) service, providing  
56 universal coverage, free at the point of use. Doctors were initially co-opted into the  
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3 system from private practice, with guarantees of clinical autonomy (Kirkpatrick et al,  
4 2005), and were involved in the running of hospitals, as dominant members of decision  
5 making teams, until the late 1970s (Harrison and Pollitt, 1994; Ackroyd, 1996). In  
6 Poland, until 1989 the country was under communist rule and the Siemaszko model  
7 prevailed, with central government responsible for providing a universal health service,  
8 free at the point of use. Doctors held clinical decision making roles within hospitals, but  
9 like other professionals during this period they were poorly paid and their collective  
10 power was weakened, by virtue of Physician Chambers being banned (Dent, 2003).  
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20 Political change in the late 1970s in the UK, and a decade later in Poland, has led to  
21 change in each system. In the UK, a neoliberal government came to power with  
22 monetarist policies and a desire to improve the productivity and cost effectiveness of  
23 the health system, with management reforms, including a new management cadre  
24 mandated to make change, introduced (Kirkpatrick et al, 2005). In Poland, the fall of  
25 communism in 1989 paved the way for a new system, based on the German model of  
26 funding through social insurance. In conjunction with this, responsibility for provision  
27 of services was devolved to regional and local governments (Boulhol et al, 2012).  
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37 Despite different political orientations and funding mechanisms the 1990s saw a move  
38 to a greater market orientation in both countries, with the separation of purchaser-  
39 provider interests (for the UK see Ferlie et al, 1996 and for Poland see Boulhol et al,  
40 2012). In the UK, primary care organisations have become purchasers of care, with  
41 hospitals the main providers. The private sector has gradually entered the frame as  
42 providers of certain, mainly routine, services. Management responsibility of NHS  
43 hospitals has been devolved to hospital level, through the creation of NHS Trusts and  
44 Foundation Trusts which are run by an executive board (Dopson, 2009). This move to  
45 Trust status required greater involvement of senior doctors in management  
46 (Ashburner, 1996, Thorne, 1994). In Poland, a number of initial insurance funds were  
47 combined into one 'National Health Fund' (NFZ) with 16 provisional branches in 2003,  
48 such that there is now one purchaser of health services. 'Public hospitals' (previously  
49 owned by central government) have been passed to local governments and universities  
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3 (Boulhol et al, 2012) and are now legally independent institutions, run by a CEO who  
4 has full financial responsibility. Encouraged by central government, a number of local  
5 governments have transformed public hospitals into 'non public' hospitals, operating  
6 under the same legal framework as commercial companies (Sagan et al, 2011). As in  
7 other new EU member states (particularly post-communist countries), private hospitals  
8 are increasingly entering as providers (Ryc and Skrzypczak 2009). While the total  
9 number of hospitals has remained much the same over the last decade, the share of  
10 private hospitals has risen steadily to around 30% in 2009 (Boulhol et al, 2012). All of  
11 this raises the question of how doctors might be engaging with these new governance  
12 and management arrangements. The next section outlines our findings.  
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### 20 21 22 23 **3. Findings**

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26 Medical engagement with management can be viewed in two ways, as participation *in*  
27 management or as enthusiastic involvement *with* management (Ham and Dickinson,  
28 2008). The paper firstly outlines the management roles that hospital doctors hold  
29 within the UK and Poland, before moving on to consider the ways in which the empirical  
30 data suggests their enthusiasm for involvement may be changing.  
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38 Doctors hold similar medical management roles within hospitals in each country. At  
39 senior level they may be CEOs or Medical Directors. However, our interviews suggest  
40 that the CEO role in Poland is increasingly held by non-medical personnel, and a recent  
41 report in the UK (Ham et al, 2010) suggests that only around 5% of UK CEOs are  
42 medically qualified. In contrast, the Medical Director role in both countries is the  
43 preserve of a doctor and a board level position. However, doctors' influence in the role  
44 appears to vary, with some Medical directors in the UK having input into strategic  
45 decision making, while others act in a more advisory capacity (Kirkpatrick et al, 2009),  
46 as they do in Poland.  
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56 When it comes to involvement at other levels within the respective hierarchies, there  
57 are more differences between the two systems. In the UK, a unit level role has existed  
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3 since the 1990s in the form of the Clinical Director, who is responsible for one or more  
4 specialities grouped as a directorate. This role is predominantly held by a senior doctor  
5 (consultant) and is a 'hybrid' (Llewellyn, 2001), in being part-time and straddling both  
6 the clinical work and managerial worlds. There tends to be a 'troika' type arrangement  
7 at this level, similar to that seen at hospital level in Denmark (Kirkpatrick et al, 2009;  
8 Dent et al, 2012) with the Clinical Director operating alongside a business and staff  
9 manager, sometimes a nurse (Ferlie et al, 1996; Dopson, 2009). They are responsible for  
10 service delivery as well as staffing, contracting and marketing of the directorate's  
11 services. Clinical directorates now have sizeable annual turnovers, ranging from £15m  
12 to £45m per year (Audit Commission, 2007).  
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23 Such a unit level role does not currently exist in Poland. Rather, 'chiefs of ward/clinic'  
24 are the important management roles (Krajewski-Siuda and Romaniuk, 2008). These are  
25 similar to Clinical Director roles but on a smaller scale, with the post held by a senior  
26 doctor who reports to a Medical Director and is responsible for all ward operations.  
27 Chiefs' level of responsibility varies, however, with some but not all chiefs having  
28 responsibility for the financial standing of the unit. According to a hospital manager  
29 interviewed:  
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37 "where a system of internal budgeting exists there tends to be a greater focus  
38 on the financial performance of the ward [but] a lot depends on the  
39 personality of the chief, in terms of their approach to financial issues and  
40 their relationships with clinical colleagues and managers. There is no prior  
41 management training." (Hospital Manager, Public Hospital)  
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46 The fact that where such a system of internal budgeting exists bonuses may be paid to  
47 staff and new equipment purchased if the ward budget is not overspent (Baczewski and  
48 Haber, 2010) might explain the greater focus the above hospital manager spoke of.  
49 However, relationships with clinical colleagues are important to doctors in both  
50 countries. In the UK, while the CEO may appoint a Medical Director, candidates need to  
51 have the credibility of their peers (Fitzgerald and Ferlie, 2000; Thorne, 2002) and  
52 Clinical Directors have historically been nominated and appointed through peer  
53 selection. Since 1998, doctors in Poland have also had considerable influence over who  
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3 holds medical management roles, as well as into health policy (Ministry of Health,  
4 1998).  
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10 When it comes to enthusiastic involvement with roles such as Clinical Director and Chief  
11 of Ward the research found historical differences between the two countries. In the UK  
12 the medical profession overall has historically resisted involvement (Ham and  
13 Dickinson, 2008; Harrison et al, 1992; Kings Fund, 2011). While a few consultants have  
14 enthusiastically taken on the role of Clinical Director (Fitzgerald, 1994; Kitchener, 2000;  
15 Forbes et al, 2004), many have been reluctant to do so (Dopson, 1996; Fitzgerald and  
16 Ferlie, 2000; Forbes et al, 2004). Reluctance has been attributed, amongst other things,  
17 to the negative impact on collegial relations, with tensions between Clinical Directors  
18 and other consultants being an issue (Fitzgerald, 1994; Thorne, 1997; Fitzgerald and  
19 Ferlie, 2000), as well as tensions with general managers. For instance, a survey of UK  
20 clinical and non-clinical managers, which included responses from 445 Clinical  
21 Directors, found that Clinical Directors were the most dissatisfied with the clinical-  
22 managerial relationship, owing to a perceived lack of autonomy and involvement in  
23 management decisions (Davies et al, 2003). A Polish CEO interviewed noted similar  
24 tensions between clinical and managerial staff in Polish public hospitals. In the UK, a  
25 lack of training and preparation for doctors to take on management roles has also been  
26 cited as a potential reason for doctors' reluctance to take on such roles (Forbes et al,  
27 2004; Fitzgerald et al, 2006).  
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44 In contrast, doctors in Poland have reportedly "tended to be attracted to the chief of  
45 ward role because of the influence that it gives them" (Polish Hospital Manager), in the  
46 way some physician-executives have in the US (Hoff, 1998; Montgomery, 2001). This  
47 may be because they have enjoyed a broad range of autonomy, appointed for six years  
48 and often holding the role for longer (Sagan et al, 2011). Both the hospital manager and  
49 former Vice-Rector interviewed suggested that management roles have historically  
50 been attractive as a way to increase Polish doctors' salaries, which were extremely low  
51 under communism and for many years afterwards (Whitfield et al, 2002; Dent, 2003).  
52 Certainly the lack of financial incentive, in the form of a higher salary, for taking on a  
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3 medical management role in the UK has been cited as a potential cause of doctors'  
4 reluctance to take on roles there (Ham and Dickinson, 2008; Ham et al, 2010). However,  
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6 according to one interviewee, whilst Polish doctors may have been influenced by the  
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8 financial incentive to take on management roles they have not necessarily had a desire  
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10 for the responsibility of management, such that many Polish chiefs of ward have been  
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12 reluctant to make change:

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14 “they may like the influence and salary, they don’t desire the responsibility of  
15 the role, owing to the tremendous sense of “solidarity” that exists, and they  
16 are more likely to maintain the status quo than to introduce change”  
17 (Hospital Manager, Public Hospital)  
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21 Given the changes that have occurred in each country in recent years, such as the salary  
22 increase for Polish doctors (Kautsch and Czabanowska, 2011) and increasing  
23 opportunity for them to work in the private sector, the fact that in the UK the medical  
24 academy now advocates doctors’ engagement with management and supports  
25 management training, albeit under the guise of ‘leadership’ (Tooke, 2008; Academy of  
26 Medical Royal Colleges, 2010; Spurgeon et al, 2011), we were interested to know  
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28 whether engagement with management may actually be changing.  
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37 In the UK, we found that recent work with Medical and Clinical Directors suggests that  
38 this group are now fairly well aligned with general managers and with management  
39 ideas such as the need to improve the quality of care (Giordano, 2010), with senior  
40 doctors having respect for financial professionals (The Audit Commission, 2007).  
41 However, whilst a Medical Leadership Competency Framework (MLCF) developed by  
42 the Medical Colleges is now officially incorporated into all undergraduate and  
43 postgraduate curricula, data collected from 22 postgraduate specialist trainees in the  
44 UK suggests that they are not aware of it, unless they happen to be participating in a  
45 specific development programme. These doctors did, however, recognise and accept a  
46 need to engage with management ideas, although not necessarily to take on executive  
47 roles such as that of CEO role:  
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3 "I think you do have to be management savvy, but I think there's a point at  
4 which...I can't see personally many doctors wanting to become chief  
5 execs...because that's not for us, that's for people who've trained in business.  
6 I think advisory stuff, clinical directors, that's great" (Specialist Registrar,  
7 UK)  
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11 These findings support other work which suggests there is a growing recognition within  
12 the UK medical profession of the need to engage with management issues and work in  
13 conjunction with managers (Levenson et al, 2008).  
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19 In contrast, in Poland there is as yet no similar profession or policy led focus aimed at  
20 developing doctors' management and leadership skills, although public health  
21 departments of universities offer post graduate courses in management (see for  
22 example, Institute of Public Health, Jagiellonian University Medical College). Here, it  
23 seems that other changes may be having an impact on engagement. Firstly, doctors are  
24 better paid than they once were (Kautsch and Czabanowska, 2011). Secondly, some  
25 Polish doctors are starting to become self-employed, joining with colleagues to form  
26 cooperatives who contract their services to both 'public' and 'non public' hospitals  
27 (Boulhol et al, 2012), akin to arrangements under the Dutch model (Dent, 2003). It is  
28 suggested that such contractual, fee-for service relationships in the Netherlands have  
29 kept doctors at "arms length" from management (Neogy and Kirkpatrick, 2009, p.6).  
30 Polish interviewees suggested that both of these factors are resulting in doctors being  
31 less interested in chief of ward and even CEO posts than they once were, as they now  
32 have opportunities for increased income without having to take on the responsibilities  
33 of management. Thirdly, it seems that there is a change in the type of doctors now  
34 taking on the chief of ward position:  
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47 "Rather than being appointed on the basis of their age and political  
48 connections, doctors are now more likely to be appointed on the basis of  
49 what they know and can do....chiefs of wards are getting younger, in their  
50 forties and fifties as opposed to their fifties and sixties. Doctors are also  
51 taking such posts as a step in their career path, rather than as a position for  
52 life as was once the case" (President of All Poland Association of Non Public  
53 Hospitals and former Vice-Rector of a University Medical College)  
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3 In addition to changes in attitude amongst doctors themselves, a hospital CEO  
4 interviewed suggested that the increase in private hospitals may mean that chief of  
5 ward posts are becoming less available than they were previously in public hospitals.  
6 Private hospitals, she suggested, increasingly prefer to employ “ward managers” (who  
7 may now be nurses) or “doctors managing the ward”, with these roles having less  
8 power than the old chief of ward role. Interestingly, despite this she suggested that the  
9 attitude of doctors towards management in privately owned hospitals was better than  
10 she had encountered in public hospitals:  
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18 “they understand that good management is crucial for the survival of the  
19 organization, accept change, initiate necessary change, and overall are more  
20 cooperative both with managers and among themselves” (CEO, Private  
21 Hospital).  
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24 This more positive attitude was attributed to the fact that private hospitals have less of  
25 a “them and us” mentality between managers and clinical staff than publically owned  
26 hospitals, benefitting from being smaller and a tendency for an “open-doors” policy  
27 which enables the CEO and clinical staff talk to each other frequently, such that issues  
28 can be solved more swiftly. What then might we conclude from all of this? The next  
29 section moves on to discuss our conclusions and the possible implications.  
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#### 38 **4. Conclusions and potential implications**

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40 This study found that doctors hold similar types of management roles in Poland and the  
41 UK, albeit with differing levels of responsibility and accountability, particularly with  
42 regard to financial affairs, and historically different levels of enthusiasm. However,  
43 there are signs that engagement with management may be changing in both countries.  
44 In the UK, there appears to be greater acceptance of the need for involvement amongst  
45 younger doctors. One explanation for this is the fact that the medical academy has  
46 recently moved to support engagement, alongside which there is a determined effort to  
47 provide management development opportunities for doctors. However, given the lack of  
48 awareness of the Medical Leadership Competency Framework amongst postgraduate  
49 level doctors, this might suggest that they are aware of the academy’s expectations and  
50 accept them, but are simply unaware that these expectations have now been formalised.  
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3 Alternatively, other factors may be driving this attitudinal shift. Whatever the reason,  
4 one implication of this attitudinal change is that doctors in the UK might engage more  
5 readily with management roles in the future. Whether and how they do so may,  
6 however, depend on what is driving their acceptance of the need to be involved. It may  
7 also depend on whether training and development is sufficiently widespread, and able,  
8 to prepare doctors for the management roles they will be required to undertake and to  
9 develop the skills and attitudes needed for such roles. At present all of this remains  
10 unclear (Noordegraaf, 2011).  
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19 In Poland, the expert informants interviewed suggest that medical engagement with  
20 management there may, in contrast, be on the decline. This is attributed to new working  
21 arrangements made possible by the move to a mixed market, as well as increases in  
22 doctors' salaries, which are reducing the financial impetus for doctors to move up the  
23 management hierarchy. One implication of the opportunity to work in co-operatives,  
24 contracting services to hospitals, is that it might lead to greater stratification within the  
25 profession overall, as Freidson (1994) suggested. As traditional management roles are  
26 re-shaped within the private sector, doctors there may also find themselves losing some  
27 of their traditional influence to other professionals, particularly nurses (Abbott, 1988).  
28 This new context may, however, also provide opportunities for a broader sense of  
29 collegiality, cooperation and partnership to evolve between doctors and managers,  
30 certainly if the CEO of a private hospital interviewed is to be believed. If this is the case,  
31 then new, more inclusive and collaborative forms of professional community might  
32 emerge, as some have predicted (Adler et al, 2008). This might mean that doctors share  
33 influence with others, through co-operation and integration, rather than dominating  
34 through positions of authority. In both countries, the full import of changing  
35 circumstances has yet to be realised. It might be that rather than seeing convergence,  
36 we actually see a switching of positions, with Polish doctors becoming less interested in  
37 management as UK doctors become more engaged with it.  
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##### 55 **5. Limitations and future research opportunities**

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57 While this study suggests that medical engagement with management is changing in  
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3 both systems, further work is needed. We have hypothesised, based on interviews with  
4 experts in the system, that market changes in Poland are creating conditions which are  
5 reducing doctors' interest in previously sought after management roles. However,  
6 further work is needed to verify this and to explore how widely this is occurring. In  
7 particular, more work to map current medical management roles in Poland and  
8 engagement with them is needed, as this has been seriously neglected within the  
9 literature. In the UK, while the empirical data collected and an emerging literature  
10 suggest that attitudes towards management are becoming more positive amongst  
11 younger doctors this needs to be explored in more detail. In particular, the extent of  
12 change and what is actually driving it, and whether the current investment in  
13 championing medical leadership and educating doctors is able to increase engagement  
14 in the longer term. As the UK health system undergoes change, with the introduction of  
15 new clinical commissioning groups, the impact of this for medical manager roles will  
16 also need to be investigated. As such, our findings suggest a number of avenues for  
17 potentially fruitful future research.  
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