prescribing options offers the better quality. To achieve this all four aims would be considered as ordinal scales within a problem. When we use the example given at the start of this paper we see that the effectiveness and risk of both hypnotics were equal and so irrelevant to the decision. This clarifies that the trade off was between the cost saving resulting from using the cheaper treatment against respecting the choice of the patient. Had I been using the aims of good prescribing proposed in this paper I hope my decision would have been a better one.

I am grateful to Dr Alan Cribb, of the Centre for Educational Studies at King's College, London, who helped clarify my thinking throughout this work, particularly in refining the issue of patient choice.

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Rethinking Consultants

Alternative models of organisation are needed

Fiona Moss, Martin McNicol

This is the final article in a series on the changing role of hospital consultants

Anyone considering a fundamental rethink of the role of consultants risks exposing tensions in the medical profession that have characterised the development of medical practice since the 18th century. That tense story was one of beds and money, power and domination. Rethinking the role of consultants must now take into account the relationship between consultants and their specialist colleagues and general practitioners; examine the distribution of work between consultants and junior doctors; and relate the contribution of the consultant as specialist to that of other health professionals. After half a century of a national health service characterised by equity of access to care, we urgently need to debate the roles of those who work in it and in doing so to focus primarily on the needs of patients.

Consultants are the senior doctors in the hospital and community services of the NHS. We discuss here their role in clinical specialties in the hospital service. All patients seen in hospital are nominally looked after by a consultant. This is a consultant's primary role, but there are others. While training, all doctors work for a consultant. In theory, most consultants are trainers and educational supervisors. In the hospital a consultant often has organisational responsibilities ranging from that of managing a clinical firm to that of medical director. Many consultants—not just those with academic appointments—take part in research and teach undergraduates. Consultants have allegiances outwith their hospitals to royal colleges or specialty associations, and some have considerable responsibilities to these groups.

So rethinking the role of the consultant means unravelling the complex package that makes up a consultant's job. The central consideration in any change should be the needs of patients for the clinical services provided—and therefore the needs of the employing organisation. Here we consider only those parts of consultants' roles that relate to their clinical base—their roles as specialists, as trainers, and as managers. It is not that other functions are not important or not necessary, but care of patients must be the primary concern. Nevertheless, in rethinking the consultant's role endorsing this function of linking with outside agencies may be important.

Box 1—Changes in nature and delivery of health care

- Medicotechnological advances
- Place of treatment and care for many common conditions—for example, the shift to day care and increasing emphasis on outpatient and community management of many conditions
- Increased throughput and reduction in the average length of inpatient stay
- Changes in the relationship between doctors and other health care professionals, with, for example, the introduction of nurse practitioners
- The purchaser-provider split and new relations between primary and secondary care

The specialist role

WHY A RETHINK?

Despite much change in the nature and delivery of health care (box 1) old patterns of work remain. The clinical component of the timetables of many of today's consultants looks much like their predecessors': regular outpatient clinics, twice weekly ward rounds, operating lists, and clinical meetings. Audit meetings and, for some, outreach clinics may have been added.

The changes in medical technology are well known. But considerable change has occurred in the pace and place of the delivery of hospital care. Between 1982 and 1992 beds available for "general and acute care" fell from 199 000 to 153 000, yet the number of cases treated rose from 4 709 000 to 5 986 000. The resulting 65% increase in throughput (cases per bed increased from 23·7 to 39·1) was accompanied by an increase in day cases of 160%, from 685 000 to 1 785 000.[1] The implications of these changes in delivery of care alone warrant consideration of the roles and organisation of all health care professionals. But with the added implications of the Calman report on specialist medical training[2]—that fewer doctors in training grades will be available for delivering services—this review is needed urgently.

The role of a consultant as a specialist is not always a clear one. In some instances it is apparently distinct—for example, the technical contribution to surgical care, the specialist opinion, the planning of treatment programmes. But nurses and other non-medically trained health professionals now carry out some technical tasks previously regarded as exclusively

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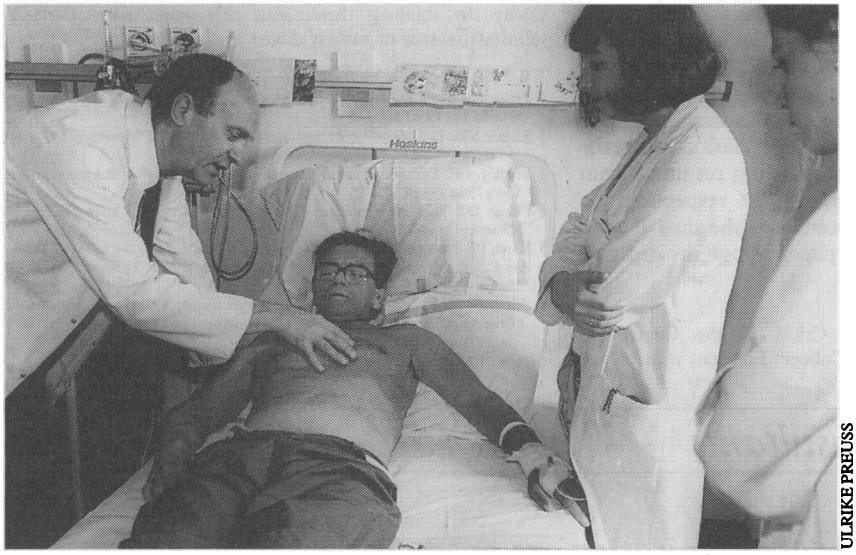

ULRIKE PREUSS

Consultants who train or manage should be trained to do so

medical—from simple tasks such as venepuncture or cervical smears to parts of major surgical procedures. Nurse practitioners and midwives are among those who clearly exercise clinical judgment. Senior house officers, who will not have started specialist training, often see patients attending consultants' clinics without supervision.[3] And non-consultant medical staff are the main doctors for patients admitted as emergencies.

What constitutes specialist care is considerably blurred; such care is clearly not confined to care given by consultants. But we will not attempt to define "the specialist." The definition in the Calman report is implicit: a doctor who has completed a recognised programme of specialist training and obtained a certificate of completion of specialist training. Instead we suggest that the appropriate focus for rethinking the consultant's role is probably the specialist team because care—and its organisation—increasingly centres on teamwork.

The role of consultants, who were once described in terms of the numbers of beds they controlled, should be considered as the medical contribution to multiprofessional specialist teams. Some consultants might say that as nurses are on "their staff" they already work in teams. But this discussion is about developing genuine teams that work effectively.[4] In its recent report on the work of hospital doctors the Audit Commission commented, "Many consultants still practise as individuals rather than part of a team."[3] Team working is difficult, and with teams based on the needs of patients rather than professional custom consultants will not in all circumstances be the team leaders.

This approach might seem to diminish the influence of consultants. But the focus should not be on the influence of one group but on the needs of patients and general practitioners for specialist care and opinion. The development and promotion of the roles of nurses, physiotherapists, and other practitioners is an important factor when considering specialist care. Often the service offered by these specialists is simply better. From a patient's perspective the choice for specialist help for back pain may be between instant access to a physiotherapist or a 12 week wait to see a consultant (or senior house officer). The different professions have complementary roles. These roles should be acknowledged, explored, and developed so that patients benefit.

By widening the scope of the debate opportunity exists to consider the particular role of the doctor in a specialist team. Opinion, judgment, diagnosis, and prescribing are all medical functions—but not exclusively so. But doctors' scientific, interpretative, and technical skills and understanding of the evidence base of clinical practice are crucial if patients are to benefit more from effective and appropriate care and be subjected to fewer ineffective and inappropriate interventions.

Many such deficiencies in the quality of health care have been shown. Guidelines based on valid evidence and adjusted to local circumstances may be one approach to promoting effective care.[5,6] Successful implementation of such guidelines is likely to depend on the participation of all those who contribute to care.[7] Consultants should be leading the development and implementation of local practice policy.

THE MEDICAL FIRM

Medical firms are past their "use by date." Firms were part of the organisation of teaching of surgery in 19th century London.[8] They became a feature of voluntary hospitals and were introduced into most hospitals at the inception of the NHS. According to Honigsbaum, this move "deserves to rank as the one great change in practice organisation made by the health service."[9] Firms, based on the needs of a single profession, with three training grades were suggested by Sir Will Spens in 1948.[10] The drawbacks to this system—present from the start, investigated by the Platt committee,[11] and responsible for today's huge organisational problems—are the imbalance between entrance to and exit from training grades (with a very heavy reliance on doctors in training grades to do service work) and an inevitable tension between service and training.

The structure based on firms is unlikely to survive the implementation of the Calman report. A new method of organisation is needed. One based on the contribution to care of all health care professionals might be more robust than this outdated 19th century model. Hospitals should be encouraged to consider better ways of organising their professional workforces and be allowed to experiment with different ways of working.

Emergency and routine care: can they be managed together?

The pattern of consultants' work depends on specialty. Some consultants are almost entirely clinic based; others also do elective surgery. But most are committed to inpatient, emergency, and clinic work. Operating sessions are a central feature of surgeons' timetables. We consider the roles of consultants in outpatient clinics and acute emergency care separately. In some respects the roles may be the same, but the forces and opportunities for change may be different.

ELECTIVE CARE

Outpatient care—In terms of sheer numbers this is the most active part of the hospital service. Over four times as many people attend clinics as the combined number of inpatients and day cases. And more people are seen as new outpatients than are admitted and treated as day cases; but three in four attendances are for follow up appointments.[1] Most specialist opinion is given in outpatient clinics, yet it is the part of the hospital service that is least well looked after. And the training of doctors in outpatient care may be no more than cursory. In some specialties—for example, diabetes care—outpatient care is the product of team work.[12] Such an approach allows the construction of working patterns that focus on patients' needs and provides more flexible and accessible delivery of care. Access is to the service and not simply to the consultant. For example, general practitioners may simply need access for their patients to, say, specialist chiropody or expert

funduscopy, and the nurse specialist may be the appropriate person to assess the needs of people with newly diagnosed diabetes. Scope exists for a properly developed team approach in many other areas. New developments in information technology provide an increasing number of methods and techniques that could be exploited to increase general practitioners' and patients' access to specialist care.

Elective surgery—Most surgery is elective. Surgeons are tied to the availability of theatres and fixed theatre times. But the changes in surgical technology, the increasing day case load, the move towards preassessment clinics, and the reduction in inpatient elective work is changing the role of doctors who are training on surgical firms. Questions about the most appropriate people to provide routine surgical postoperative management and the primarily medical problems when these occur postoperatively will help to inform debate about the best way of organising the professional structure to support surgical care.

Box 3—Working definition of a consultant

"A gentleman, no doubt as a rule of superior culture and knowledge of his profession, who sees patients at his own house at stated hours, who is quite willing to visit them at home if requested to do so; it being understood that he confines his practice to medicine or surgery as the case may be; and that the rate of his remuneration is higher than that usually accorded to the practitioner. He is, in fact, a practitioner (though exclusively medical, surgical or obstetrical) among the rich, or among those willing to pay a guinea or more for each consultation or visit. As, a point of fact, the ordinary general practitioner so called, finds the bulk of his work in medicine or obstetrics, the difference between him and the consultant really resolves into a difference of fees. We are not objecting to this. The difference of remuneration generally corresponds with a superior value of the opinion of the consultant."

BMJ 9 Feb 1878, p 197[14,15]

RELATIONSHIPS WITH GENERAL PRACTITIONERS

The relationship between consultants and general practitioners has at times been sticky (boxes 2 and 3). Continuing difficulties in this relationship are suggested by the problems that some general practitioners have in getting specialist attention because of long waits for appointments or because patients are not seen by consultants and because of the somewhat superior view of some consultants about what they regard as "inappropriate" referrals.

General practitioners' referral for specialist advice for their patients has been much researched.[16] But as general practitioners become increasingly influential purchasers of care, consultants will have to work with them to develop new approaches to accessing specialist services. Funnelling all referrals through to consultants is likely to produce impossible workloads, but specialist care could be made more easily accessible and widely available if good use is made of specialist teams and modern information technology. Consultants must listen to the needs of general practitioners and their patients and work with general practitioners to improve access to specialist care.

ACUTE CARE

Consultants' contribution to emergency work is vexed. The problem is connected to the twin issues of the hours and conditions of work of junior doctors[3] and the quality of care.[17] Expecting older doctors to do regular night duty is probably not appropriate. Their younger, fitter colleagues are likely to be better at it. But those looking after people who are acutely ill must be appropriately trained. Patients fare better when, for example, they are operated on by trained surgeons or properly supervised surgeons in training.[18-20] Evidence suggests that some groups of patients with acute problems fare better when looked after by the relevant specialists or specialist teams. The current system of organising work is not the best arrangement for either patients or doctors in training.[3]

Box 2—Referral of a patient

"The consultant should be applied to for advice by the practitioner, and not by the patient; that the advice should be for the instruction of the practitioner in the management of the patient, and not for the instruction of the patient, who having no technical knowledge can profit little by it. Since the practice of medicine has been more scientific and more specialised it follows that the practitioner is required, in the interests of his patient, to seek the advice of a consultant more frequently than was considered necessary in the past and a 'need has arisen for a class of men who will act as consultants in the strictest sense of the term.'"

BMJ 12 June 1886[13,14]

The importance of effective multiprofessional teams and of the often pivotal role of specialist nurses in particular, in the highly technical areas of intensive care, casualty departments, and acute admissions wards is well recognised. The diagnostic and technical skills of doctors are also crucial and may need to be immediate. But too often, and particularly in casualty and acute admission areas, these skills are provided by doctors in training.

Responsibility for delivery of acute care is a fudged issue. How does the notion of continuing responsibility fit into a model where the consultant may not know about the care being delivered in his or her name? And the cross cover systems necessary to produce vaguely manageable workloads for doctors in training grades can make lines of accountability indistinct.

In the best circumstances care is delivered by a team with access to guidelines for care. A crucial and challenging question about the consultant's contribution in these circumstances is: what is the particular skill or knowledge that he or she contributes to care? Many decisions do not need to be made by a consultant. And, given the multiplicity of their commitments, consultants often cannot be fully and directly responsible for patients nominally under their care. What is the contribution of a consultant to a patient needing acute intervention if he or she is at an outreach clinic? If reality is that continuing responsibility is an impossible demand then should not this be declared and a fresh look be taken at the issue of responsibility and accountability for care of patients?

The current pattern of mixing acute inpatient and clinic care may not be the most effective pattern for patients, consultants, or doctors in training. Already some teams with enough consultants organise their work so that, for example, for one week in five one team is dedicated to emergencies and does not undertake routine work. Separation of acute and elective functions may be both a more effective and a more efficient way of working.

Training

The recommendations in the Calman report focused on the training needs of junior doctors. The work of that committee was prompted by European Union legislation. But a crisis in medical training has existed for some time, with increasingly intolerable and insuperable tensions between service and training. A contractual responsibility for the education and training of medical staff in training grades is being sought, with more rigorous educational supervision

and appraisal. The transfer of half the funding of training grade salaries from hospitals to regional postgraduate deans[21] is one sign of a new approach.

The introduction of the recommendations of the Calman committee will further emphasise the need for consultants to be trainers, a role that will be more demanding than today.[2] Not all consultants will need to manage training, and those who do so will require training in educational methods, and their work as trainers will be broadened, designated, and include appraisal and review of the trainers as well as the trainees.

Educating and training future generations of doctors will include developing skills for 21st century health care. There will have to be a much clearer and formal emphasis on the need to evaluate the evidence on which clinical interventions are based and competence in communication and team work, as well as technical and diagnostic skills. Consultants as trainers will have to do far more than nod encouragingly on ward rounds as tired junior doctors hurriedly present cases.

Management responsibilities

The management role of consultants gained status after the introduction of general and resource management. And management for many consultants now exceeds the "committee work" referred to by Sir Will Spens in 1948[10] in his recommendations for the remuneration of consultants in the new NHS. The development of management responsibilities is often added on to a consultant's work. Many consultants are paid for managerial responsibility in terms of extra sessions, but few give up clinical sessions. Potential disadvantages for both the individual and the trust exist in this approach. Management skills do not come automatically with appointment as a consultant, but consultants need to be competent managers to organise their routine duties, set up services, or run departments.[22] Some managerial training will be a necessary part of specialist training.

Management roles for consultants need to be considered as a further specialist function for which aptitude and training are needed. Individuals may choose or be chosen to develop a further managerial function beyond the basic needs of their own work. If these roles are important to trusts then resources, including time and training, should be made available.

What's in this for the consultant?

It is difficult to define a medical or consultant role, other than as part of our social custom. With the wide variety of career options for consultants, individuals may occupy different roles at different times. The job of a consultant after 10 years often only partially resembles that on initial appointment. Perhaps one of the attractions of a career as a hospital consultant is that it is put together over the years like a collage. New opportunities and challenges emerge. But this "add on" approach to consultant development may be partly responsible for some of the stresses in today's hospital system.

Being nominally on take, doing an outreach clinic, and having managerial responsibility for a clinical directorate—all at once—is not a particularly coherent way of working. In the end it will not benefit patients or trainees and is certainly an inefficient use of consultants' experience and time.

Consultants should not expect or be expected to do three jobs at once. Clinical specialists need to focus on assuring the delivery of effective and appropriate care to the population. Their role as experts in emergency care may need to be separated from their role as specialists to a population. Those who train or manage should be trained to do so and given the time to do these things properly.

Conclusions

The Calman committee's proposals look daunting. But doctors in training, who, with nurses, have absorbed most of the pressures of the relentless increase in the pace of delivering care, need a better deal. If this is to be achieved then changes in the organisation of health care professionals are essential. Getting the roles of senior specialists sorted out must be part of a bigger rethink of the best way to deliver health care. The health service needs to start considering and trying alternative models of organisation now—remembering that after the implementation of the Calman recommendations the number of trained and certified specialists will increase as the training will be shorter. The changes needed may be painful. But unless the service faces up to the need to restructure and reorganise, everyone, especially patients, will be losers.

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