meetings. There is thus conflict between commitment to the service as a whole and commitment to individual patients' care.

The report may be used by some managers to put further pressure on consultants to adhere inflexibly to their job plans, to operate more quickly, or to see more outpatients per session. Such moves might jeopardise the good will of the many for the sake of the few bad apples. Action, however, is going to be taken, but perhaps the report does not go far enough. Instead of tightening up on job plans should we not review the whole concept of medical firms? If shift work is appropriate for junior doctors and, incidentally, most other health care workers might it not be appropriate for senior doctors? Teams of specialists could then work together to cover all commitments, both clinical and managerial. This would ensure an equitable distribution of work among doctors. Continuity of care might suffer, but the trade off would be that patients would always be supervised by a specialist. The debate is under way.

PETER JACKSON
Consultant in obstetrics and gynaecology

Huddersfield Royal Infirmary,
Huddersfield,
HD3 3EA

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Consultants of the future

Need to acknowledge organisational goals and play to their strengths

Few people disagree that the work of British consultants is changing rapidly. The questions revolve around how consultants should organise their work to meet a set of apparently conflicting demands on their time. Over the past four weeks we have invited contributors to discuss these issues,[1-4] and last week the BMA's consultants' committee hosted a meeting at BMA House to think about the future role of consultants. Consultants clearly believe that they have been dancing to others' tunes for too long and that, in the words of Jim Johnson, the consultants' chairman, it's time to take charge of their own destiny.

Change is needed because of reductions in junior doctors' hours; the proposed change to shorter, more structured training for juniors[5]; demands from purchasers that more work is done by fully trained specialists; and the requirements of the new NHS: audit, contracting, and managing. Scientific advances[3] and changes in the pace and place of care[4] also make change essential. The net effect is that heavier workloads leave consultants with little time to reflect on how they can best use their time.

Teamwork is one solution. If fewer juniors are available for service work, more of that work will have to be done by consultants. Although consultants work more efficiently than juniors, the large amount of emergency and night work presently done by juniors remains a problem. Bigger teams make this more manageable. In the United States, for example, senior doctors in a cardiology service carry out virtually all the clinical work, much of it outside hospital but including night work and emergencies.[1]

Alternatively, others can share the work. Nurse specialists already have important roles in the services for many patients with chronic conditions, such as diabetes and asthma,[4] as well as in acute services such as intensive care. Experience with nurse practitioners and physician assistants in the United States shows there is scope for more.[1]

But such changes call for doctors to stop "insisting on doing things where we should share skills. . . . Many of the things that senior house officers do badly nurse practitioners do well." This plea to last week's conference from Cyril Chantler, principal of the United Medical and Dental Schools of Guy's and St Thomas's and one of the pioneers of doctors in management in Britain, was to identify where consultants' strengths lay. Like Kenneth Calman, the chief medical officer, he argued that the doctor's real role is in diagnosis[6]: treatment and care can and should be shared with others.

Those responsible for organising services need to think through the issue of "what skill or knowledge consultants contribute to care."[4] Rees argues that what characterises specialists is "their ability at the margin of knowledge."[3] But this in turn suggests that there is much behind the margin that consultants can abandon to others as they advance at the margin.

Teamwork also requires good management. "Efficient care requires teamwork, and management is about getting teams to work well," said Cyril Chantler last week. Indeed, management, in one form or another, looms large in consultants' futures. Not only do some need to train for and take formal management positions; even consultants with no formal management roles need skills and training in recruitment and selection, procurement, handling complaints, time management, and marketing, Nick Naftalin told last week's conference. As medical director of Leicester Royal Infirmary he also wants consultants to shift their sights from their own self directed professional learning to include the needs of their department and hospital.

Naftalin argued that clinical directorates should set their own strategic goals and back them up with appraisals (in which individuals are set objectives and their performance in meeting those objectives is assessed). "How can you get people to change unless you appraise them?" His hospital has started a consultant planning programme, in which clinical directors set objectives for each consultant and discuss with that consultant his or her needs for career development. So far a third of the consultants have taken part, and those who have done it have acted as advocates to persuade others.

Naftalin also emphasised the benefits of such appraisal to individuals' career patterns. It was, he said, a way of enhancing people's strengths and not insisting "they do things they don't do well." There was resistance to this idea among those who attended last week's conference, many people preferring to have consultants nominally responsible for everything as at present, their careers evolving in response to chance and their own interests. But Moss and McNicol suggest that putting together a consultant career like a collage, "adding on" responsibilities haphazardly, is not a coherent way of working and may in fact contribute to the stress that

many consultants feel.[4] They argue that different consultants should do different things, suggesting not only that some consultants should specialise in teaching or management but also that some might specialise in acute work and others in elective work, some in outpatients and some in inpatients.

One fear undermining such specialisation, however, is the fear of engendering second class consultants. Currently consultants differ in pay, workload, on call responsibilities, and teaching commitments, and last week's conference couldn't agree whether it mattered whether consultants did very different things, so long as they had clinical responsibility for individual patients.

If consultants remain wary of formal appraisals those at last week's meeting seemed much more comfortable with the concept of peer review as outlined by Brian Harrison of the British Thoracic Society. The society has a voluntary scheme whereby two reviewers visit each department and review and report on the facilities and organisation of the service. Responses from both the reviewers and reviewed have been almost uniformly positive. Schemes like this, and the already well established accreditation scheme for pathology departments, will undoubtedly grow and help to contribute to the maintenance of standards and the cross fertilisation of ideas. Clinicians also like these schemes because they cross the organisational barriers imposed by the internal market and the resulting competition between trusts.

But trusts and their aims cannot be ignored in today's health service. Thinking about the aims of the trust seems alien to many doctors—partly because of their "professional duty to the individual patients"[3]; partly because they didn't have to do it through the first 43 years of the NHS (and aren't trained to do it); and partly because of the crude way that some trusts have developed their organisational goals, excluding rather than engaging consultants in the process. Bailey points out that the current multiplicity of ways in which consultants can theoretically influence a trust's policy serves to confuse and that trusts need to evolve more effective ways of allowing consultants to influence and implement trusts' policies.[2] He points to Sweden, where the chiefs of the clinical services sit on hospital boards.

Developing a service (and a career) in line with a trust's aims shouldn't be a problem for consultants if, firstly, those aims are directed towards serving the hospital's patients and, secondly, those consultants have played a strong enough part in the process of evolving these aims. Consultants might feel beleaguered at the moment, but there are few people (even among their critics) who do not want to see them fully engaged in making the health service work—not just clinically but strategically and managerially. And that means, firstly, that they have to manage themselves and their colleagues more than they have been used to.

JANE SMITH
Deputy editor

BMJ
London WC1H 9JR

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Tuberculosis: old reasons for a new increase?

Socioeconomic deprivation threatens tuberculosis control

See pp 963, 967, 974

Notifications of tuberculosis have increased in England and Wales over the past few years, as in other European countries and the United States.[1-3] An estimated 8000 extra cases occurred between 1982 and 1993 in England and Wales, but the 95% confidence interval is wide (3000 to 12 000).[1] At least part of the increase may be an artefact—for example, the creation of consultants in communicable disease control in 1988, together with local initiatives (such as that described by Brown and colleagues (p 974),[4] may have resulted in a substantial fall in the undernotification previously reported in several areas.[5] The increase in notifications has been largely for non-respiratory tuberculosis,[1] in which the new consultants may have had their biggest impact—undernotification is more likely in specialties other than respiratory medicine. On the other hand, evidence exists that undernotification of tuberculosis, particularly in association with HIV infection, is still common.[6]

Factors contributing to a real increase are likely to be multiple and may vary among areas and populations. Notifications of tuberculosis in Britain fell steadily long before specific chemotherapy was available. It was recognised in 1899 that "the most powerful factors in producing tuberculosis are—(1) air contaminated by the so-called tubercle bacillus, (2) food inadequate in purity, quality and quantity, (3) confined and overcrowded dwellings, (4) a low state of general health and resisting power of the body."[7] The fall was attributed primarily to improved socioeconomic conditions and the isolation of infectious cases. Temporary increases in tuberculosis associated with wars were explained by poor nutrition, overcrowding, and fewer beds in sanatoriums.[8] The continued fall after effective treatment was introduced was slowed but not reversed by the arrival of immigrants from countries with a high prevalence of tuberculosis.[9] Much higher rates, particularly in the Indian, Pakistani, and Bangladeshi ethnic groups, have been documented on several occasions over the past 30 years.[10-12] The increase in notifications since 1988 is of particular concern as it seems that immigration may not be the only factor and indeed may not be the most important one in some areas. The papers from Mangtani *et al* (p 963)[13] and Bhatti *et al* (p 967)[14] in this week's journal indicate that socioeconomic deprivation may also be important. Nevertheless, disentangling the effects of deprivation from those of belonging to an ethnic minority on the incidence of tuberculosis is almost impossible.

Unsurprisingly, in the 32 London boroughs tuberculosis is associated with unemployment and immigration; of more concern may be the association between recent increases in both tuberculosis and unemployment.[13] In Britain the greatest increases in tuberculosis between 1980 and 1992 occurred in the poorest 10% of the population (on the basis of the Jarman index). In this group notifications increased by 35% compared with a national increase of 12%. Indeed, an increase occurred only in the poorest 30% of the population. The increase in the borough of Hackney (with a rate four