Education and debate

Role of specialists in common chronic diseases

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Consultant care is currently available to only a small proportion of people with chronic illness. How can we enable many more people to benefit from specialist expertise?

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Most people with chronic conditions such as diabetes, congestive heart failure, asthma, and depression are managed in primary care. NHS consultants have traditionally confined their role to patients who are referred to outpatient clinics by their general practitioners. Such patients usually have the most severe and complex problems. Effective care teams for chronic illness must be able to cross practice or organisational boundaries,[1] but the current organisational structure of the NHS does not provide many incentives to develop such linkages. General practitioners refer patients they cannot manage and hospitals are funded on the basis of referrals. Time spent on joint work with primary care is not accounted for. To ensure that all patients get the best treatment, the role of consultants needs to change so that their specialist knowledge is more available to everyone dealing with chronic disease.

Changing roles

In recent years nurses in the NHS have taken on a larger role in managing patients with chronic disease. Specialist nurses work alongside both general practitioners and consultants to assist in managing people with complex problems in both hospital and community settings, and practice nurses now act as case managers to patients with conditions such as diabetes in primary care. However, there has been little integration of primary and specialist care through shared information systems and clinical protocols, such as that seen in US health maintenance organisations.[2]

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Many US managed care programmes use specialists as part of the primary care team

During a research fellowship spent in a health maintenance organisation,[3] I had the opportunity to observe and discuss how the role of the specialist might differ from the traditional role. On the basis of my experience I believe that changing the role of consultants requires two key conceptual shifts.

Population perspective

The first shift required is a departure from being concerned only with patients who are referred to outpatient clinics. Population based care is an approach to planning and delivering care to defined populations that tries to ensure that effective interventions reach all patients who need them.[4] Specialists need to consider how they can improve the quality of care for those people who don't need, or don't get, to see them and how they can ensure that those who do need to see them actually do. This is broader than simply a public health perspective; it is about taking a leadership role in planning effective clinical care for a population with the extended team across primary and secondary care. It requires thinking beyond the door of the clinic. Consultants in the United Kingdom rarely do this at present.

Designing stepped care pathways

The second shift is to introduce stepped care. The concept of stepped care has been around for about 10 years in the chronic illness field.[5,6] In stepped care models most patients are seen in primary care, and only patients with more complex problems receive direct specialist input. This sounds the same as traditional care. However, in a stepped care model patient outcomes are monitored so that patients can be "stepped up" and "stepped down" according to individual need and preference. It is this monitoring of outcome data combined with regular clinical supervision that is different from usual, often ad hoc, practice.

A stepped care protocol differs from a normal protocol in that it contains explicit agreed indications for when a patient should ascend or descend the pathway. These indications are based on clinical data, which are recorded in a data system or registry under the supervision of a case manager and are accessible from different points in the pathway. For a stepped care pathway to work effectively across the spectrum of illness, generalists and specialists need closer working relationships. Collaboration is required to set up the pathway, ensure that everyone enters data, and for supervision and consultation to be available from specialists.

Many US chronic disease management programmes use specialists as part of the extended care team. In the model described by Katon and colleagues (table), the specialist has no role in the care of people at step 1 but offers supervision to the case manager for people at step 2 who are not progressing. Specialist consultation with the general practitioner is provided at step 3, and specialists take over care completely at step 4. Only a minority of patients will see the specialist, as in traditional systems of care. However, the specialist will have an indirect but important role in the other levels of the pathway, primarily through education, consultation, and supervision. He or she will also have a crucial role in the definition and systematic assessment of an adequate outcome.

In Katon and colleagues' model the term specialist is assumed to mean doctor, but for some conditions it could also mean a non-medical specialist. Nurse specialists have been shown to be effective in improving outcomes in a range of conditions, notably diabetes.[7] Nurse specialists provide more than basic case management. They are also skilled in delivering more complex interventions,[8] as dictated by the care protocol, in consultation with the consultant.[9] Nurse specialists could thus also provide supervision and support to the case manager and general practitioner, involving the consultant when needed.

This approach is not synonymous with coordinated care, which may not include the tailoring of interventions to severity or efficient use of case management.[10 11] Stepped care has been shown to be effective when implemented as part of a comprehensive restructuring of care, including promotion of self management, case management, clinical protocols, and specialist support.[12 13] Undoubtedly more research is needed, but the increasing policy emphasis on disease management is already putting on pressure to change the consultants' role in chronic illness.[14] The role that I propose has three key components, clinical, educational, and leadership.

Box 1: Structured approach to consultation in primary care

- Case manager provides care according to protocol in liaison with general practitioner and enters quality and outcome data in record
- Specialist nurse provides extra input to certain patients according to protocol and supervision or advice to case manager and general practitioner as required
- When the consultant visits, patient list is selected by the team after a review of the register to ensure that people with complex needs, greater severity, or failure to progress are reviewed
- Consultant may consult jointly with patient and members of the care team to ensure everyone agrees a care plan

Box 2: Qualities needed by specialists

"Someone who's very smart, but at the same time, really can embrace that sort of cooperative attitude . . . I know a lot, but don't know everything, how can we work together on this?" (patient)

"You have to have a real comfort level with your specialty . . . you know the specialists you can call and who you know, there's more of a camaraderie . . . those people who are really helpful on the phone are the people who really listen . . . they're the people who are the best clinicians too; they really listen to the patient so they're also listening to their colleagues so they can give you good advice." (primary care physician)

"We should say, 'We're here to help you. Tell us what you need help with?' Some of the people that do this work are fairly arrogant." (specialist)

New role

The clinical role requires consultants to work more closely with general practitioners and specialist nurses or therapists, advising on treatment and lifestyle alterations. This will usually mean visiting the health centre, which improves the relationship across the primary-specialist interface. The consultant provides the specialist overview, being the member of the team most up to date in the specialty.

The approach differs from the consultation liaison or outreach clinics, which have had a chequered history in the NHS.[15] All carers are working from the same stepped care protocol and information system and a case manager oversees the process. The key is ensuring that the consultant is used appropriately (box 1). The consultant might travel around several clinics and carry out joint consultations with the doctor or nurse and

Model of stepped care (adapted from Katon et al[6])

Level	Status	Practitioner roles
1	Preventive services and diagnosis of subclinical disorders	GP provides screening, diagnosis, preventive services, and patient education and monitors outcome
2	Newly diagnosed disorder, relapse or exacerbation of chronic disorder	GP diagnoses, prescribes treatment, and recommends lifestyle changes. Case manager ensures continuing contact, monitors symptoms and side effects, provides self management support, and refers back to doctor if patient fails to progress. Specialist supervises caseload of case manager
3	Failure to progress in level 2 care	Specialist consults with patient and GP and recommends change in treatment or lifestyle; specialist may provide several visits, preferably within primary care
4	Failure to progress in level 3 care	Specialist takes over care for patients who are not making progress in level 3 or those with higher initial levels of complexity

Summary box

Most people with chronic illnesses are never seen by a specialist

The specialist should have a key role in improving quality of care outside the clinic

This requires more effective bridging of the primary-specialist interface for people with chronic illness

Stepped care protocols can incorporate appropriate use of specialist expertise

patient. Joint consultations would serve an educational as well as clinical purpose[13] and could even replace the majority of traditional outpatient appointments. A specialist who values this way of working told me:

In this setting, because the doc and the nurse know the patient inside out, they can bring me up to speed really quickly, I can then go in and get to the meat of what matters to the patient very early. We can also work out a whole series of things they might try, and so often what I try and end up doing is laying out some options for a variety of things over the next six months. So the patients often feel as if they get a lot out of it and the primary care team feels as if they've been supported. They've got several things they can try and they're still in control.—specialist in health maintenance organisation

The consultant has an educational role through regular meetings with staff at all levels. These meetings should provide supervision and support but also build mutual trust by acknowledging that the consultant has a lot to learn about primary care. The consultant should also take the lead in improving quality of care and getting the processes in place.[16] System change takes time, diplomatic skills, effective communication, and good working relationships. Primary care teams have to adapt to having a new member, and successful collaboration requires patience and humility. People I spoke to at all levels of the care process identified various qualities required by consultants (box 2).

Conclusions

Consultants have a key role in chronic disease management as part of the extended care team. They are well placed to collaborate in designing stepped care protocols, provide decision support and consultation to nurse specialists and primary care providers, and specialist interventions to patients with complex needs. Above all, they have a leadership role in bringing about innovation and change.

This paper is based on detailed observations, interviews, and discussions with primary care physicians and specialists across the United States during a Harkness fellowship in healthcare policy and practice supported by the Commonwealth Fund of New York and based at the Center for Health Studies, Group Health Cooperative, Washington, USA. These were informed by a Medline search of the literature using combinations of the free text search terms: specialist, consultant, chronic disease, stepped-care, and integrated. Martin Roland provided helpful comments on an earlier draft.

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Corrections and clarifications

Abstinence only programmes do not change sexual behaviour, Texas study shows
During the editorial process two errors crept into this article by Janice Hopkins Tanne (*BMJ* 2005;330:326, 12 Feb). We wrongly said that Doug McBride, a spokesman for the Texas Department of State Health Services, was also an author of the Texas study reported in the article. We also said the evaluation of the programmes was prompted after Democratic Senator Henry Waxman and others complained that 11 of the 13 commonly used programmes included false and misleading statements; in fact, the evaluation programme was already under way before Senator Waxman reviewed the programmes and said he found errors.

Association between suicide attempts and selective serotonin reuptake inhibitors: systematic review of randomised controlled trials
The authors of this paper, Dean Fergusson and colleagues (*BMJ* 2005;330:396-9, 19 Feb), have notified us of some incorrect values in the Results section (fourth paragraph of print version and sixth paragraph of full version). The odds ratio of fatal suicide attempts for selective serotonin reuptake inhibitors compared with tricyclic antidepressants should be 1.08 (0.28 to 4.09) (not 7.27 (1.26 to 42.03) as reported). They state that this does not affect the main conclusions or the main message of the article.

Obituary: Alfred Ian Douglas Prentice
In this obituary by J B Enticknap (*BMJ* 2005;330:542, 5 Mar) we were quite clearly mistaken in saying that Dr Alfred Ian Douglas Prentice died in August 2005; he died in August 2004.