was by the Primary Health Care Development Fund, the Welsh Scheme for Health and Social Research, and Novo Nordisk. The South Glamorgan Medical Audit Advisory Group and the region's family health services authority have funded the project since 1992, and the former continues to recruit practices to the scheme and organise opportunities for practical continuing education for each audit meeting on diabetes. The participating doctors, nurses, dieticians, chiropodists, and others with a specialist interest in diabetes determine the direction of the programme and keep it flourishing through their enthusiasm and their administrative, educational, and clinical efforts. The practice nurses of South Glamorgan deserve special mention for their dedicated care and follow up of patients.

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(Accepted 12 January 1995)

Rethinking Consultants

Time for change in traditional working practices?

John Bailey

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

Consultants in Britain are under pressure to change the way they organise their work. Many rely on formal, but unwritten, rules and a culture of "learning by doing." Unlike their counterparts in Sweden, they are often not well integrated into the management systems of their hospitals. The result is wide differences in the NHS workloads of individual consultants and, for a minority, conflicts of interest with their private work. The training received by junior doctors varies because it is largely left to individual consultants. Clinical directorates should provide a more effective mechanism for consultants to influence trust policies and for consultants to implement these policies. Consultants must not only recognise the need for change but also seize the initiative.

Consultants are under pressure worldwide from changing health care technology, patient expectations, and the demands of governments for greater efficiency. In the United Kingdom the government's policy on hospital medical staffing is to increase the level of direct patient care provided by consultants.¹ Many consultants have changed their clinical practices in response to these pressures, but the way in which they organise their work has changed much less. It is based on a long

tradition of medical hierarchies with formal, but unwritten, rules about who should do what and a culture of "learning by doing."

The role of the consultant has two essential characteristics: autonomy and a position as leader of the "consultant firm." Increasingly, both are resulting in significant problems which ought to be addressed.

Consultant autonomy

Consultants carry a heavy burden of responsibility for patient care. They are legally responsible for all aspects of their patients' medical care, irrespective of the extent to which they personally deliver the care. Clinical freedom—the concept that individual doctors must base their decisions about patient care on their own judgment about what is best for the patient—ultimately rests with consultants because all other hospital doctors work in some way under consultant supervision. It is not surprising that consultants have a high status and considerable autonomy.

Until recently consultants were probably the main players in deciding how health care resources are used, but in Britain and in many other countries this role is now being shared with health care purchasing bodies, which have been set up specifically to determine what

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BMJ 1995;310:788-90

Many doctors would benefit from a clearer specification of what is expected of them and a more even distribution of work

health care is needed for a community and to agree contracts with hospitals and community services to provide that care. Purchasers and providers are concerned to ensure that the methods of delivery of health care are as efficient and effective as possible so as to maximise the amount of care provided within their budgets. They are setting boundaries of expectations within which consultants and their staff must deliver services and are involving consultants in aspects of the service outside their traditional role, such as clinical audit and negotiating service contracts. These changes are beginning to expose a series of problems, the solutions to which will challenge consultants' autonomy.

UNEVEN SHARING OF WORK

The uneven sharing of NHS work among consultants and the low levels of work carried out by a minority are important problems. The Audit Commission's report on the work of hospital doctors in England and Wales has shown that the number of theatre sessions attended each week by some consultant surgeons varies as much as sixfold within a single specialty (figure) and that, after differences in the complexity of cases have been taken into account, attendance is the major determinant of the amount of operating a consultant does—more important than the length of sessions or the speed of working.² Similar results were obtained for both surgeons' and physicians' work in outpatient clinics.² Although these results may partly reflect circumstances outside an individual consultant's control—for example, insufficient theatre or outpatient clinic capacity—and different emphases in a consultant's work, the commission also found that a consultant's job plans were often non-existent or incomplete and that about a third of consultants missed more than 1 in 10 of their fixed commitments.

CONFLICTS OF INTEREST

The conflicts of interest between consultants' work within the NHS and that outside it are also a problem. Full time NHS consultants are free to undertake private practice at any time, and many have contracts which allow them to do as much private work as they wish, as long as they "devote substantially the whole of their professional time to the NHS."³ There is no information to allow assessment of whether the extent of consultants' private practice has an effect on their meeting their contractual NHS commitments. It is possible, however, to examine the relation between private practice and the amount of work carried out for the NHS. This shows that although most consultants

do not do private work at the expense of the NHS, the 25% of full time consultants doing the most private work tend to do significantly less NHS work than their colleagues.²

Leader of the firm

Each junior doctor has traditionally been part of a "firm" led by an individual consultant. The firm structure has two main rationales: continuity of care and apprenticeship training. Continuity of care is the notion that patients should see as few individual doctors as possible so that contact between all concerned is easier and knowledge about the patient is contained within the firm; and apprenticeship training depends on the idea that junior doctors work closely alongside a consultant and learn from him or her.

The firm in its pure form has not existed for many years in the NHS because junior doctors often work for more than one consultant during a single period of duty. Moreover, the availability of junior doctors has declined recently as a result of government policy in Britain. The government has also sought to reduce the number of junior doctor posts relative to consultant posts. This is so that consultants participate more in patient care and to promote a smoother career progression for junior doctors. In addition, there have been moves to reduce junior doctors' hours of work and the length of their training.

Junior doctors who provide on call emergency cover usually care for all patients in their specialty when on duty, not just those in their particular firm. However, the culture of "learning by doing" that is associated with the firm still prevails. This means that juniors are expected to learn the ways and unwritten rules of each individual consultant they work for and apply these rules according to whose patients they are treating at the time. In the absence of clear guidelines on the roles and tasks of junior doctors and the circumstances in which they should ask for help there is a risk that some junior doctors may take on more than they are competent to do. Evidence exists that they do so.⁴

The spread of the work of junior doctors across several consultants has also meant that both of the underlying rationales for the consultant firm are disappearing. Informal contact between doctors in the firm cannot be maintained as the basis of continuity of care in which patients may be seen by several doctors

Number of operating theatre sessions attended each week by consultants, based on three month survey of operating theatres including 106 consultants in 10 hospitals. Includes only whole time and maximum part time consultants working exclusively in the hospital and assumes an average of two weeks' leave during survey

from different firms. The scope for apprenticeship training is reduced because doctors of different grades increasingly work separately and in different locations in a hospital.

Clinical directorates, in which one consultant takes on the role of clinical director and is responsible for the directorate's use of resources, were introduced to involve doctors more in management. But few clinical directors have managerial authority over consultants or junior doctors in their directorates. In practice, clinical directorates are mainly a mechanism for managing budgets—that is, controlling the amount of money spent in the directorate.⁵ Because of that they have not been able to take on the task of ensuring that all resources are being used efficiently and effectively.

What needs to be done?

Fundamental changes are needed in the role of consultants. Consultants are increasingly recognising that they are not free to use NHS resources purely on the basis of their judgment of what is best for individual patients. Their judgment must be set within the priorities and guidelines agreed in the broader context of the decisions about community needs and service constraints that are made by purchasers, trust boards, and clinical directorates. Of course, individual consultants should have an important input into these decisions, but this does not always happen. The management arrangements of many trusts need to be changed to provide a more effective means for consultants to influence trust policies and a mechanism for consultants to implement these policies.

Currently consultants can influence a trust's policy through several channels: clinical directorates; the medical director, who is a member of the trust board; and medical advisory committees comprising some or all of the consultants in the trust. This multiplicity of channels means that communication between consultants and a trust's managers and board is sometimes poor because the appropriate lines are not clear.

If consultants are rightly to be given more influence over trust policy then they must act as integral players in the trust and accept that their work must be governed to a greater extent by agreed trust policies. The system of clinical directorates that already exists in many hospitals in Britain could provide the basis for a much more effective management system for consultants, and for junior doctors too, if clinical directors were given the authority to manage. In Sweden, for example, senior doctors in the role of "chiefs of division" have been given such authority, and consultants are much more effectively integrated into hospital management (box).

In Britain similar changes are within the existing powers of trusts as long as they have the agreement of

Management arrangements for doctors in Sweden

Doctors in Sweden often have a much greater role in the management structure of hospitals than doctors in Britain. In many Swedish hospitals three key doctors in management roles—that is, those responsible for medical specialties, surgical specialties, and other specialties (radiology and pathology) are members of the hospital board alongside the directors of finance and personnel. In effect they replace the role of medical director in Britain, who often performs a role that is much more advisory than managerial. These "chiefs of division" are responsible for all aspects of care within their divisions, including the management of doctors (services relating to cleaning, catering, leisure facilities etc are managed separately for the hospital as a whole). The management lines below divisional heads are clearer than in the clinical directorates in Britain because the chiefs of division rather than individual consultants carry ultimate responsibility for patient care, and the need for clarity in working arrangements is recognised. The clinical freedom of individual specialists to treat particular patients is slightly more restricted than in Britain because the system is built around basic guidelines at division and specialty levels; the principle, however, is strongly upheld.

the doctors involved. Not only could such changes improve patient care, but many doctors would benefit both from a clearer specification of what is expected of them and of what support they should receive and from a more even distribution of their work. The risk of a consequent reduction in clinical freedom might be more imagined than real.

There is now a real opportunity for change, and the appearance of this series of papers on the role of consultants is a welcome sign. Consultants themselves must seize the initiative and not only recognise the need for change but also be at the forefront of it.

I thank the Audit Commission for permission to write this paper, which is based on work undertaken on its behalf. The views expressed are entirely mine and do not necessarily represent the views of the Audit Commission. Special thanks are due to staff at the Swedish Association of County Councils and at Stockholm's Huddinge University and Lowenstromska Hospitals for explaining the intricacies of the Swedish hospital management system.

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Medical notes—the patient's contribution?

Over the past five years I have been an outpatient at three hospitals, have seen five consultants, and had countless appointments, all of which relate to the same illness. Each time I see a different doctor I have to relate the history of the illness, investigations, and treatment. The first time that I saw a different consultant I was unprepared. I found it hard to remember some of the details as I had assumed wrongly that all the facts would be in the referral letter. After this visit I sat down and summarised my medical history, initially as an aide memoire for myself and partly to help any other doctors I saw. I update it as necessary.

This summary contains my presenting symptoms, course of the illness, investigations carried out, treatment, and, for me the most important part, the real problems of the result of the illness. This is on my computer. I now produce a handout for each consultant. It helps me when I

have to relate the pattern of what is now a complicated illness. After five years I have got it to a fine art. I hope that the hospital staff also find it of benefit as they do not have to thumb through a wad of notes, letters, and investigations. An added benefit is that it has given me a greater feeling of participating in my medical treatment.

Many people are surprised I do this, but one doctor said he wished that more patients would follow my example. Perhaps more patients should be encouraged to contribute to their own notes, particularly when they have a long or complicated history.

I long for the day when I can wipe off the information. Meanwhile before every appointment to a new hospital department I run off the latest instalment for my medical notes.—VALERIE LOBBAN *lives in Edinburgh*