special articles

Psychiatric Bulletin (2005), **29**, 182–185

JUDI EGERTON, ALAN SWANN AND BARRY FOLEY

Shadowing consultant psychiatrists: the need for change

AIMS AND METHOD

To explore the role of the consultant psychiatrist using an observational approach. Five consultant psychiatrists were shadowed by a trained observer. Observations were subjected to a qualitative analysis based on a grounded theory approach.

RESULTS

Six themes emerged as being significant; these were administration and secretarial support; training aspects of the role; clinical activity; the referral process; supervision, support and continuing professional development; and organisational systems.

CLINICAL IMPLICATIONS

The results indicated significant difficulties in the role of the consultant psychiatrist and the need for change. Any change in this role would have an effect on the roles of other professionals and on the whole system in which they work.

The Changing Workforce Programme, a part of the National Health Service (NHS) Modernisation Agency, has the task of exploring new ways of working and of helping to develop new roles, with the aims of responding better to the needs of service users, increasing job satisfaction and retaining staff. A particular aspect of its work is to address the crisis in medical staffing in psychiatry, particularly the shortage of consultant psychiatrists. These issues have been highlighted in a report by the Royal College of Psychiatrists (2001) and by Kennedy & Griffiths (2001). The Changing Workforce Programme undertook this study within the mental health pilot sites to obtain detailed information about 'a day in the life of a consultant psychiatrist', in an attempt to look at what the consultant's role is now and how consultants might want to change it.

Method

The investigation took the form of a small qualitative study, using grounded analysis, of five consultant psychiatrists. Information was collected by means of a brief questionnaire, followed by observation and formal, non-structured interviews. We are aware that the observation or shadowing process of one role can only offer a snapshot of the role and the organisation. The observers were informed 'outsiders', i.e. they had a background in the NHS as mental health professionals, but were not part of the departments being observed. The study comprised eight stages:

1. negotiating entry;
2. obtaining consent;
3. the contract;
4. period of observation and questionnaire;
5. the report;
6. follow-up interview;
7. coding and collating;
8. the final report.

Negotiating entry

One consultant volunteered to participate from each of five Changing Workforce Programme mental health pilot sites, providing a self-selected sample. Three were consultants in general adult psychiatry (one in an inner-city teaching hospital and two in hospitals with combined urban and rural catchment areas) and two were consultants in old age psychiatry in inner-city teaching hospitals. We asked each consultant to consider four questions prior to the observation period:

- What do you do that you feel is part of your role and is effective?
- What do you feel could be better undertaken by somebody else?
- What would you like to do that you are not able to do at present?
- What are the factors that prevent you from doing this?

The first consultant was observed over a 5-day period to test the study design. The other consultants were observed for 1 day only, on a date negotiated between the observer and the consultant. All the consultants provided a copy of their timetable in addition to completing the questionnaire.

Consent

Guidance was taken from the Department of Health. Ethical consent was not required, as the observation process did not impinge on patient care. Verbal consent was obtained from each consultant and the role of the observer explained to all staff and patients involved.

Contract

Prior to the start of the project, discussion took place about how information would be used and made anonymous. Guidelines were agreed about whom the information belonged to, with whom it could be shared and the clinician's right to edit it.

Observation

The observers recorded all information related to task, activity and role, asking questions for clarification purposes. In addition, each consultant's medical secretary

https://doi.org/10.1192/pb.29.5.182 Published online by Cambridge University Press

special articles

was interviewed for 30 min, to obtain a fuller picture of the consultant's role. At the end of the observation period there was a 30 min debriefing period, allowing the participating consultant an opportunity to reflect on the observation process and to discuss any issues that had arisen.

Report

The report was composed of a brief description of the consultant's job situation and the main themes observed.

Follow-up interview

The interview took place 1–2 weeks after the consultant had received the report. The interview enabled in-depth discussion of the report to take place and changes to be made to it where necessary.

Coding and collating

The Changing Workforce Programme team gave each interaction a code and these were collated into emergent themes.

Final report

The final report included information about the context within which each consultant worked, the questionnaire, the timetables and the time log from the observation period, and a full report on the data collected. Feedback from the consultants was incorporated into the final report and added to the data. Comparisons were made between consultants working in different geographical areas and different specialties.

Results

The main themes that emerged were administration and secretarial support; training aspects of the role; clinical activity; the referral process; supervision, support and continuing professional development; and organisational systems.

Administration and secretarial support

Each consultant spent 4–8 h per week on administrative tasks. Some of these tasks were appropriate for consultants, but some were not and could have been performed by a competent personal assistant. Some consultants felt guilty and responsible for the high workloads imposed on their secretaries. There were additional compounding factors such as poor information and media technology systems and unclear roles for lower-grade administration and clerical staff.

Training aspects of the role

Each consultant had some involvement in training junior doctors. The consultants working in the teaching hospitals had more time allocated to teaching and supervising junior doctors. One consultant had the role of college tutor, but owing to a large clinical case-load was unable to fulfil this role in its entirety, leading to stress in the individual concerned.

Consultant support for junior doctors varied widely. The consultants who worked with a specialist registrar had more time to spend on organisational tasks such as leading new projects and initiating change.

Clinical activity

The consultants observed had appointments with 30–50 patients per week. These included in-patients, out-patients, day patients and new referrals. Where there were fewer junior doctors the consultants had a far higher number of patients; these consultants would have liked to reduce their case-loads but found it difficult to do so. There were complex issues highlighted around the accountability of responsible medical officers (Kennedy & Griffiths, 2002). Consultants who had large case-loads were providing a good-quality service to their patients but were frustrated by their lack of time for involvement in organisational strategy, and their experience and leadership skills seemed not to be used effectively by the organisation.

Referral process

The referral pathways varied enormously, from referrals entering the system in a haphazard way, to a system in which all newly referred patients were seen by a consultant psychiatrist for their initial assessment. This variation depended on the consultant's individual preferences and feelings of anxiety and uncertainty about other professionals' ability to do initial assessments. This was related to the uncertainty about the exact responsibilities of the consultant, including the confusion over responsible medical officer status. The consultants' thoughts about changing the system ranged from anxieties about the skills and competencies of other professionals to the length of wait a patient might have if not referred directly to the consultant. Two of the consultants seemed to be filling voids in their service. One consultant seemed to be part of an effective multidisciplinary team where referred patients had a single point of entry to the system, were discussed by the team as a whole and allocated to the most appropriate member of staff for initial assessment. The whole team then discussed the assessment. In this team the consultant was observed to have a consultative role, seeing the more complex cases, and offering containment and clinical management.

It was unclear whether members of the multidisciplinary teams understood each other's skills and competencies and the lines of accountability and expectations seemed unclear in some teams.

Two of the consultants had concerns about record-keeping and patients' case notes; they made a good case for a single multidisciplinary record.

https://doi.org/10.1192/pb.29.5.182 Published online by Cambridge University Press

special articles

Supervision, support and continuing professional development

The consultants who were working in the hospitals with combined urban and rural catchment areas seemed more isolated with less support than the consultants working in the large teaching hospitals. Access to support, mentorship and continuing professional development (CPD) varied for each consultant. Access to support, mentorship and CPD was better for consultants who were part of a team, whereas the more isolated consultants seemed to be unable to make space for CPD. In addition, even if the consultant timetabled a space for CPD or supervision, this was often lost owing to the demands of clinical work and other unplanned activity. Access to study leave varied, but consultants working with a large peer group found taking this leave easier because cover was available.

Organisational systems

In all areas there seemed to be a shortage of services, such as psychological therapies, and of staff, such as psychiatric liaison nurses, community nurses, occupational therapists, clinical nurse specialists and nurse consultants. Many teams and services were being developed across primary, secondary and tertiary care, and how all these systems interact is confusing to all involved – particularly the patients. Greater role clarity and flexibility, improved care pathways and effective management would lead to improvements in the use of existing resources.

Discussion

This is the only study that has explored consultant roles in the NHS from an observational position. The observational method highlights issues that are not always reported by individuals themselves. Despite the small sample of consultants, the study showed wide variations in practice.

The consultant role differed from that of other professionals in that consultants seem to be positioned on the boundary of all professional groups and at the interface between primary, secondary and tertiary care. They were observed to take a broad view of the patient and the treatment options available. The assessment they offered was specific to their role, in that it included physical, neuropsychological, psychological, psychosocial and pharmacological aspects. They were able to explore diagnosis by ordering specific investigations, prescribing and managing medication regimens.

All the participating consultants found the space to reflect on their role in their organisation useful, and the majority went on to make some changes to their role. What is evident is that consultants cannot change their role effectively in isolation. Changes to the consultant's role would result in changes to all the other professionals' ways of working, including those at the primary care level. A whole systems approach to changing roles is essential.

Areas in need of review and change

It is unacceptable that medical secretaries are overworked and that consultants feel guilty and responsible for this. Our study suggests that two secretarial roles are required: one would involve typing and answering the frequent telephone calls about patient appointments and clinics; the other would be that of a personal assistant, to perform the more complex tasks.

Some consultants were reviewing patients in out-patient clinics but doubted the value of these reviews. A review of out-patient services in relation to consultant contact would be beneficial. Regular routine follow-up could be achieved in other ways, for example by the general practitioner or another professional, or through e-mail or telephone contact.

Observations of multidisciplinary team and community mental health team meetings suggested that a review of the process of how these teams function might be useful. There seemed to be many assumptions about the roles of each member of the teams and a lack of knowledge about each other's skills and competencies. In addition, it seemed that role development at primary care level, such as specialist general practitioners or mental health practitioners, would enable consultants to deal with the more complex cases, acting in a truly consultative role when required.

The stressed consultant is often seen as having a personal problem in need of therapy. This personalises the difficulties encountered in the role. If consultants are encouraged to take the therapy option when the organisational structures are not in place to support the role, the individual continues to carry the dysfunction, when this might be more appropriately explored in an organisational context. It would be preferable to have a structure that offered consultants mentorship, clinical supervision, management supervision and leadership training. Consultants have not been offered good management in the past, and from this study it was clear that there is an absence of management of their role. A comprehensive appraisal system is now in place for all medical staff. This should lead to professional development and identification of problematic areas of the consultant role.

The more experienced the consultants, the more effectively they managed the tasks and boundaries in their role. Two of the consultants took up strong leadership positions in terms of service development and strategic management.

It seems that a cohesive and progressive role development plan would be helpful to support the consultant. There are particular concerns for the consultant working in isolation, and a need for the early identification of signs of stress and professional burnout. These findings endorse the Royal College of Psychiatrists' proposal to offer mentorship to all newly appointed consultants (Dean, 2002). This complexity of change requires a thoughtful change process and will include changes at a national level, including clarification of a consultant's responsibility/accountability.

https://doi.org/10.1192/pb.29.5.182 Published online by Cambridge University Press

special articles

Future steps

Since this work was completed, a National Steering Group has been established, chaired by the President of the Royal College of Psychiatrists and the Director of Workforce Planning at the National Institute for Mental Health in England (NIMHE), to look at roles and service provision across the mental health services. An interim report is now available on the work of this group (http://www.nimhe.org.uk/whatshapp/item_display_publications.asp?id=706).

As part of the Changing Workforce Programme and independent initiatives, several pilot sites linked to the NIMHE areas have been established where clusters of consultants are designing changes to roles and services. The authors of this paper, who have links with the National Steering Group, would like to hear from any groups of consultants who are proposing role changes.

Acknowledgements

The authors thank the consultants who took part in the 'shadowing' process for the wealth of information they provided and their enthusiasm towards the work, and Siobhan Chadwick of the Changing Workforce Programme.

References

DEAN, A. (2002) *The Role of a Mentor for Newly-Appointed Consultants*. London: Royal College of Psychiatrists (http://www.rcpsych.ac.uk/traindev/tutors/mentorsAug02.pdf).

KENNEDY, P. & GRIFFITHS, H. (2001) General psychiatrists discovering new roles for new era . . . and removing work stress. *British Journal of Psychiatry*, **179**, 283–285.

KENNEDY, P. & GRIFFITHS, H. (2002) What does 'responsible medical officer' mean in a modern mental health service? *Psychiatric Bulletin*, **26**, 205–208.

ROYAL COLLEGE OF PSYCHIATRISTS (2001) *Roles and Responsibilities of a Consultant in General Psychiatry*. Council Report CR94. London: Royal College of Psychiatrists.

***Judi Egerton** Clinical Nurse Specialist in Psychotherapy and Organisational Consultant, Changing Workforce Programme and Lecturer, The Tavistock Clinic, North Cumbria Mental Health and Learning Disabilities Trust, Carleton Clinic, Cumwhinton Road, Carlisle, Cumbria CA1 3SX, **Alan Swann** Consultant Old Age Psychiatrist and Associate Medical Director, Newcastle General Hospital, Newcastle upon Tyne, **Barry Foley** Mental Health Lead and Workforce Designer for the Changing Workforce Programme

https://doi.org/10.1192/pb.29.5.182 Published online by Cambridge University Press