# Physicians in a foreign land?

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## *Patients*

Working as a physician, it would be easy to discard the current rhetoric of a 'patient-centred NHS', after all that's surely why the NHS exists. But, in spite of its shortcomings as a concept, I suspect the arrival of the 'expert patient' is just the start of a new kind of patient at the centre.[1,2] The relationship between the public and professionals is changing: the age of deference is coming to a close. Increasingly patients will be more questioning, more demanding and better educated about their problems.

Diabetes is an excellent example and many diabetes services, led by imaginative physicians, are showing the way in bringing innovative approaches to patient education, making patient empowerment a reality. Of course some patients will continue to ask the doctor to take all the decisions but increasingly patients will seek a different relationship; a relationship based on concordance rather than compliance; a relationship of adult to adult, rather than adult to child. I envisage this, like parent/child relations, as a continuum in chronic disease management with the gradual transfer of knowledge and skills to the newly diagnosed patient to the point where they are able to take control themselves. And with control comes responsibility: when a child becomes an adult they take responsibility for their own actions, and do not blame the parent – provided, that is, the childhood was a positive experience. This will have implications for training and delivery. It will probably also require more time, initially at least, which leads to my second challenge.

## *Professional demarcation*

The current debate on meeting demand in the NHS seems to be predicated on the assumption that if we simply train more healthcare professionals we will address the problem. I don't subscribe to this view. Demand pressures are coming at us from all sides: new and better treatments, more demanding patients, an ageing and increasingly obese population. The theory also suggests that if only we could shift resources to prevention we would solve the problem: after all someone with type 2 diabetes and complications costs the NHS five to six times more than someone without complications[3] but, whilst there is scope to reduce the acute caseload through secondary prevention, I am sceptical about the scope for primary prevention because the root causes of ill health lie in society. No amount of public health intervention will counterbalance the huge commercial forces in the opposite direction led by the market. We are unlikely to have enough professionals to do the job if we continue to do things as we do them now. And there's the rub: the challenge is to go back to the drawing board and radically reappraise who does what.

Diabetes services have long been exemplars of innovation in skillmix within the workforce and there is some excellent local practice. But there are dangers in an entirely locally driven approach. Not least is that of confusion for the patient, who needs to be reassured that s/he is being seen by a professional who is qualified to do the job, but for the professional too there is a danger that it will reduce mobility within the NHS as new cadres of healthcare professional are recognised in one area and not another. For that reason I believe the Royal Colleges collectively have a responsibility – to future patients, not to politicians – to take a lead and work together to address skillmix issues at a national level.[4] They need to question their own culpability in creating barriers to change by their approach to professional demarcation under the guise of protecting patients. Understandably, many patients, and professionals, fear that re-examining who does what will lead to a 'dumbing down' of quality. This need not be the case. Provided skillmix issues are addressed within a proper competency framework, underpinned by appropriate education and training curricula, there is no reason why they should compromise quality: indeed, this may be the only way to meet the rising tide of demand.

Skillmix can also be used to create real opportunities for professional progress up the career ladder, enhance job satisfaction, enrich roles and free physicians at the top of the ladder to do the jobs they have been trained for. The principle should be that no one up the ladder does something the next person down could do, given the right training and support. And the first rung of the ladder is the patient as an expert.

### *Politics*

Some have pleaded to take the politics out of the NHS[5] but it is naïve to imagine that, as long as the NHS exists, politicians will be able to resist getting involved. The old politics of the NHS that was driven from the top down in a highly centralised approach helped to keep that politics national. The rhetoric of the new politics of the NHS, signalled by *Shifting the balance of power*,[6] is an attempt to exert less control from the centre: the politics will become local. Decisions on resources will be made locally and, in England at least, the primary care trust will hold the purse strings. To be effective in this new environment, physicians will need to become skilled negotiators with their local PCT. No longer will they be able to rely on respect for their professional status to win their case; it will have to be well argued and costed, with a proper appraisal of the alternatives. It will have to be based on an open dialogue with general practitioners and an intelligent approach to the division of labour. Physicians will therefore have to be increasingly adept politically, and they will also need to re-examine what is done by the specialist team to ensure that resources are not wasted using specialists to see patients who should properly be dealt with in the community. In disciplines like diabetes, physicians will increasingly be seen as the apex of a referral chain, providing support and advice to those further down the line, and dealing with the patients that only they can deal with. Patients, and specialist patients groups like Diabetes UK, are physicians' natural allies in maintaining quality, and will work to ensure that change is achieved without compromising quality. Physicians should look for opportunities to involve and work with patients on these difficult areas at local level.

So will the physician feel challenged in this new world? Yes – challenged to acquire new skills and adapt to a changing environment; challenged to gain leadership through respect, rather than power; and challenged to be at the centre of an intelligent debate about the role of the physician in the twenty-first century NHS.

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## References

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