The levels of medical effectiveness

One of the unacknowledged ladders in medicine is the levels of effectiveness at which doctors may work.

As medical students and junior doctors, we are trying to establish our basic level of effectiveness, which is our ability to see, communicate with, diagnose, and treat an individual patient properly. Demonstrating this ability is the focus of medical finals and Royal College exams. So the first level at which a doctor must be effective is that of the individual doctor–patient consultation. Indeed if there are questions about our competence at this level then it is unlikely that we will gain respect at any of the higher levels from colleagues, patients, or managers.

But even at this basic level, to be effective the needs of the next level come into play. The next level is that of working effectively with local colleagues; for example, collaboration between GP partners, making appointment systems work for doctor and patients, referring patients at appropriate times, and getting information transfer and handovers right. It is at this level that many of the most intractable problems, both interpersonal and systemic, in medical practice emerge, and many of the stresses of medical practice happen.

Next is work at the area-wide level on overall patterns of activities and problems within the local healthcare system. It is at this level that public health doctors start their work. It is here where primary care trusts (PCTs) function, trying to make sense of what is happening at the lower levels in consultations, and the patterns of expenditure on referrals and prescribing that arise. The PCT can see the overall numbers and costs, but need the eyes of doctors to give them understanding. Doctors working at this level tend to be involved as BMA reps, local medical committee members, in practice-based commissioning, and PCT roles and similar. At this level the focus is still local and specific, and this level provides the interface between government policy coming down, and local implementation. I suspect chief executives can give many examples of when they have 'held the umbrella up' to protect the lower levels from misdirected policies, and that Department of Health civil servants will complain that 'many policies were not implemented as they should have been.' In industry middle management is what determines the success of the company, but it rarely gets credit either from the layers above or below.

There is a regional tier of Strategic Health Authorities in the NHS but as a GP I have no idea what they do. This may be shameful ignorance on my part, but neither I, nor my patients, have come to any harm for this ignorance. They made Darzi plans last year, and this year they will have to cancel them as the funding is about to dry up.[1]

The next level up is working at national level. At this level doctors will be working for Royal Colleges on their ruling councils, or for BMA committees, or for the Department of Health, or be involved in quality control, research, and publishing. At this level the players become well-known, and develop a varying balance of influence and power — the theoretical thinkers tend to value influence, and the more practical BMA types tend to develop power.

I hope readers will recognise my description of these levels. And many of you will work at several of these levels. I doubt any of us are totally effective at each one. All of us should be effective at the basic level of individual doctor–patient interaction. All of us should be effective at the level of working with colleagues, but sadly not all of us are. Many, perhaps most, doctors choose to spend their whole careers working at these two levels and there is no shortage of work. The benefit of such a strategy is that we have senior experienced doctors working very directly with patients.[2] The disadvantage of such a strategy is that doctors tend to work in their job, not on it.[3] The tendency, worsened by increasing sub-specialisation, is to 'silo' thinking,[4] for example that 'I have done my job well' and not to look at the patient's overall journey through the system, and whether the collective result is more, or less, than the sum of its parts. If doctors are not willing to do, or at least be part of, this analysis then someone else will do it for us, who may very well have no understanding of any of the parts, and even less of their relationships.[5]

There are many tensions between working in our jobs as doctors, and working on our jobs and roles as part of a healthcare system aiming to improve and streamline the patients' journeys through it. The tensions are between time spent on one role against time on another. The tensions are between the different rewards for different activities. The tensions include the stress of trying to be inclusive while also leading colleagues, who may well be reluctant to change. The tension may be between changes we believe in, and those that we have to implement as they are official policy. The tension may be between the attractiveness of distractions and the difficulties of the current job. The tension may be between the familiar collegiality of our fellow doctors and the risk of stepping into the new world of management. The tension may be between time off and time spent at a meeting in the evening or in London.

There is a huge amount of work that needs doing on the higher levels of medicine at the area, regional, and national levels. It does need medical input. And yet most doctors do not have the training, the temperament, the time or the energy, and so never take the opportunity to contribute at these levels.

And working at these higher levels does need additional skills and training. You cannot just take any GP and appoint them to General Practitioners Committee or College council and expect them to do the role well.

I hope that by writing this article I will help colleagues by making explicit the ladder of medical effectiveness.

I want to say that the work at all levels is equally valuable: a surgery spent sorting

out the various needs of 20 patients is as valuable as attending, for example, an afternoon at the local medical committee conference. The ladder rises in terms of levels of abstraction, not of financial, clinical, or moral value. The lowest level is properly at the bottom as without it the edifice would fall down, not because it is a low level skill.

What I would like to see is contributions at all levels equally valued, as part of the necessary wider field of action of GPs, which goes a long way beyond the consulting room, and which determines the context within which our individual doctor–patient consultations will occur. And I would like to see GP jobs being planned with some elements from the different levels contained within them, according to the GP's temperament and opportunity. I would like to see this being systematically supported as an expected and valued part of GP work, not tolerated as a partner's odd foible.

Is there a way that we could make these levels cohere more usefully with each other?

Peter Davies

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First course of its kind in Scotland puts weight on obesity

A new course at Robert Gordon University, the first of its kind in Scotland, has been designed to prepare those working in the areas of nutrition, health care, and public health to tackle the escalating obesity crisis.

The course aims to provide a multidisciplinary approach to the professional management of obesity as well as a critical understanding of concepts in obesity management through a scientific and clinical approach.

The new MSc in Obesity Science and Management is being coordinated by the University's well-established Centre for Obesity Research and Epidemiology (CORE) and has just been validated by Dr Colin Waine, former chairman of National Obesity Forum and Dr Aileen Robertson, Public Health Nutritionist, lecturer at the SUHR'S University College, Copenhagen, and Regional Adviser for Nutrition and Food Security at the WHO European Regional Office.

Professor Iain Broom who leads the CORE team said:

'Career opportunities have significantly increased with the global recognition of obesity as a disease and associated health issues. Graduates will enjoy wide ranging opportunities in the healthcare and public health sector, policy development, nutritional sciences and industry.'

Dr Colin Waine added:

'The prevalence of obesity has now reached epidemic proportions and is posing an even greater threat to health than smoking. It is associated with at least 45 comorbidities among which are some of the biggest killers in modern society, such as type II diabetes, cardiovascular disease, and many important cancers.'

The first cohort of students is expected to start the new course in September this year.