Redefining the roles of a diabetes consultant: The fundamental four?


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What *is* the role of a diabetes consultant? In the past, it was quite simple: if you had diabetes, you saw a specialist; if your GP wasn't sure, he sent you to the hospital. But since then, the healthcare landscape has changed beyond recognition. A combination of inertia and possibly a false belief that "it will all go away" has resulted in future generations of diabetes trainees and consultants facing a lack of clarity about their roles, perhaps even an identity crisis.

So what exactly should be their role? Is it simply to do their specialist clinics at times of their choosing and walk away? Is it only to be the "lead" within a service and develop it, or is it more? It has been fascinating to read the views expressed on Twitter, where a significant number of patients, if not all, have asked to be "treated as a person, not a number". There has been a huge number of requests from all concerned for diabetes consultants to move away from single disease specificity and think of multiple morbidity, and thereby help primary care deal with such complex patients better.

The fundamental four

In the ever-changing landscape of diabetes healthcare, the diabetes consultant can potentially hold four roles:

1. Specialist

It needs to be accepted, perhaps, that in some areas of diabetes care diabetes specialists are better than anyone else. This is because taxpayers' money has been spent on teaching them the relevant skills, hence asking someone without this expertise to provide the same service is simply not good for patient care.

A case in point is antenatal diabetes or insulin pumps. Expertise in these areas requires special training, and even among specialists, not all have received this. Thus some areas should be niche and fall squarely under the remit of specialists, and should stay so, because of the level of care that would provide. Perhaps an open, broad debate highlighting those clear areas would be the first step (Kar, 2012).

2. Educator

However, the above represents only a tiny fraction of the diabetes populace. It is perhaps time to accept that, in the present economy, there are not the finances to support a system whereby all people with diabetes need to see a consultant. With general practice as the primary port of call, and evidence such as the "legacy effect" reinforcing the need for early intervention and diagnosis, specialists need to have a role as educator. Be it at a trainee stage or qualified physician, a diabetes specialist can contribute significantly to improving the healthcare of a person with diabetes at a surgery level by the use of virtual methods, case discussions or even reviewing patients with the local practice nurse or GP. Rapid changes in new therapies and technologies further emphasise the educator role of the diabetologist. Models of diabetes care such as that in Derby (Rea et al, 2011) and North London (Vize, 2012) are already looking at this. Often specialists have had a research element to their training that comes with skills of appraisal of the evidence – many specialists are still involved with research, which contributes to the further development of diabetes care.

Forgetting the debate as to whether primary care is providing good diabetes care or not, if we believe this not to be the case, perhaps the onus is on us to help improve the situation by education, rather than criticism.

The expertise of a "general physician", which can become a millstone inside an acute trust (with push from other specialties to accept patients who do not fit a niche), could be an enormous strength in the new commissioning era. There is a huge cry for a generalist – that "old-school" physician who could advise about multiple morbidities, not just chronic obstructive pulmonary disease and further referral to a cardiologist for heart failure. A potential expanding role as an educator and source of support for patients with multiple morbidity? The possibilities are endless.

3. Leadership

This, in my humble opinion, should be provided not only for the services a consultant runs, but also for the whole system. If we genuinely believe that we

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need to "do something" to improve public health, how about being the focal point for leading change in schools and colleges, and being active public health campaigners for sport in schools, early diagnosis, and education of the public? Despite all that is said in the media, the public still respects the opinion of a doctor, so why not be at the forefront of local media, hospital communications and local councils?

The levers that influence care in hospitals are weak, yet account for significant costs to the Clinical Commissioning Group (CCG). How does the CCG influence such an expensive condition? Commissioning for Quality and Innovation schemes (CQUINs) and Commission-defined pathways all have upfront costs. Maybe the best way is to have "someone on the inside" – smart commissioning will enable incentivisation of the diabetologist, who can see reinvestment in the patient pathway.

4. Accountability and governance

Perhaps the most important role, which stems from leadership, is willingness to be accountable for service outcomes. If the data suggest that something isn't right, then rather than challenging the data or treating it as a conspiracy, maybe it would be better to accept it and try to make the necessary improvements. If one is willing to take awards for one's services, then, by the same token, one should be ready to accept the failings too. If our primary care colleagues are willing to give us that responsibility, then at a local level the consultant should be able to lead and be accountable for the journey of a person with diabetes from diagnosis to complications. A key challenge will be how to bring clinical governance and quality standards to the whole diabetes pathway.

Will the new CCGs embrace the principle of making a diabetologist the key accountable person for the whole diabetes pathway? One idea mooted has been for the diabetes physician to take on the mantle of a general physician – an idea that has pros and cons, but one that simply does not leave time or resources for the diabetes person to be based "without walls", i.e. in both primary and secondary care.

The art of possibility

Within a hospital trust, if that's where one wants to confine oneself, a diabetes specialist can play all those roles: championing the cause of people with diabetes, improving care, and challenging others who "omit insulin" in people with type 1 diabetes. Consider using your "supporting professional activities" (SPA) time for the educational components in a structured way, rather than ad hoc. Look at the possibility of annualising departmental job plans, so that all can contribute. Learn from our anaesthetic colleagues: we envy their job plans, but educationally they have been streets ahead of us.

For those who would like to broaden their horizons, and feel that trusts are simply bastions that hold their salaries, the opportunities are perhaps even broader. Engage with public health, engage with the clinical commissioners: there has been no better time to sit down and discuss what a diabetes consultant can contribute.

A word of caution

However, restricting oneself to one niche area, acute trust or community trust is perhaps self-defeating. To quote the late Niru Goenka, the term community diabetologist is nothing but a tautology: isn't the hospital, after all, part of the community too?

Questions have been raised as to whether diabetologists should bear the brunt of general medicine within hospitals (Sharp, 2012), which perhaps implies acceptance that no other physicians carry that responsibility, or is it an attempt to perhaps "justify" their existence within an acute trust? In an environment where a diabetologist needs to straddle the divide between primary and specialist care, this step could be a retrograde one – putting resources under further pressure. The diabetologist community needs to decide which baton it wants to carry – a restricted one within an acute trust or one "without walls".

Looking ahead

In the words of Lao Tzu: "If you do not change direction, you may end up where you are heading." As specialists, we continue to mull over where we are heading, so maybe it's time for us to make sure we lead the change in direction – and the first step perhaps is to redefine what we do.

Here's hoping our primary care colleagues embrace the option of these new, redefined roles – and then maybe we might be able to stem the ever-increasing number of people with diabetes who need professional healthcare support, not debating each other's roles but comfortable in our own roles and responsibilities. I look forward to it. ■

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