tal disorders, such as depression and anxiety, rather than complex psychoses, that contribute most to this rising sickness absence. These are managed almost entirely in primary care, where the focus is on patients with apparently greater clinical needs. Effective evidence based treatments are available for these disorders, including antidepressant medication, problem solving, cognitive behaviour therapy, counselling, and collaborative management.[10] Patients tend to prefer psychological therapies,[11] but with a limited capacity to provide them the waiting times are commonly long. Novel approaches to delivery, such as computer based cognitive behaviour therapy, are still at an early stage of development. Both employers and patients require a speedier response than is currently delivered, as the longer an individual remains off work, the more difficult a return to work becomes.

Not uncommonly, a position develops where an individual has recovered sufficiently to consider returning to work but perceives that exposure to his employers, colleagues, or other aspects of work will lead to a relapse. General practitioners can have difficulty linking with employers to effect vocational rehabilitation and, as the patient's advocate, may feel uncomfortable recommending returning to work in this situation. Occupational physicians are best equipped to manage these cases, yet the United Kingdom has very poor provision of occupational health (one specialist for every 43 000 workers) compared with the rest of Europe.[1] A cluster randomised controlled trial in Holland has shown how early psychological interventions for common mental disorders, delivered through the workplace, can enhance health and reduce absence.[12] The intervention consisted of 4-5 sessions of cognitive behaviour therapy to increase activity and coping skills for those off sick for only two weeks. It reduced total sick leave, time taken to return to work, and recurrence at 12 months. If the government is serious about tackling the consequences of common mental disorders then innovative policies, possibly requiring major expansion in occupational health and provision of psychological therapy service in primary care, will be required alongside research into the most effective and cost effective methods of delivering service. This would be a wise investment given the substantial economic and social costs engendered by the current service framework.

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New professional roles in surgery

Would be effective in selected surgical settings and can offer benefits

New professional roles in surgery are a controversial issue. Recent publicity surrounding surgical care practitioners has illustrated the extent of hostility in parts of the surgical community.[1–3] Yet the landscape of the NHS is changing radically. External forces such as the European Working Time Directive are having a profound effect on the United Kingdom's healthcare workforce, and maintaining the current situation is not an option.[4 5]

The unavoidable reality is that we do not have enough doctors to sustain traditional working patterns. Therefore, developing new professional roles seems a logical response. Moreover, role redesign fits with the government's commitment to widen career opportunities in health care and to develop a flexible training structure based on individual competences rather than traditional pigeonholes such as doctor or nurse.[6 7]

Increasing numbers of medically unqualified practitioners are now being trained in surgery related practice, and this is a good time to examine the pros and cons. We write from the perspective of a large university teaching hospital in central London, with a track record of pioneering new roles. Early projects included establishing the United Kingdom's first nurse consultant in coloproctology and a nurse led minor surgery service in west London. Although now widely accepted, these roles aroused great opposition when first introduced.

More recently we have led two national pilot programmes, funded by the Department of Health and

BMJ 2005;330:803–4

drawing participants from nursing, the operating department, and allied health practitioners. The perioperative specialist practitioner programme provides preoperative and postoperative care, working alongside junior medical staff and as a part of the surgical team.[8] Participants in the Imperial surgical care practitioner pilots carry out surgical procedures, working under supervision as part of a clinical team. Other surgical care practitioner pilots have taken place elsewhere in the United Kingdom.

Our pilots show that intensive focused training can lead to high degrees of expertise in a relatively short time (one to two years), albeit within clearly defined limits. In our unpublished study, detailed evaluation, using extensive interviews by independent qualitative researchers, showed the high perceived value of these roles in many of the 22 NHS trusts that took part. Equally striking, however, were the high levels of initial anxiety and mistrust that emerged, especially among junior doctors, who felt threatened by changes to traditional working patterns. Interestingly, support for new roles was greatest outside the metropolitan teaching centres, with their traditional reliance on trainees.

At first sight, the advantages of practitioners in new roles in surgery seem obvious. Provided they are suitably trained and supervised they can provide a much needed addition to the workforce. Practitioners in these new roles will not rotate, unlike junior doctors, so continuity will improve. Direct referral pathways from primary care can be developed. By carrying out surgical and perioperative tasks such as excision of skin lesions and preanaesthetic assessment according to clearly defined protocols, such practitioners can allow surgeons to focus on managing more complex clinical problems. In time they could act as a resource for junior surgeons as they learn straightforward procedures. This would free consultants to teach more complex tasks.

However, there are caveats. These new practitioners should not be embraced uncritically or introduced solely as a response to political imperatives. Redesign of surgical roles is relatively new in the United Kingdom, and most information comes from pilot projects whose conditions may be unrepresentative. Moreover, most trainee practitioners for new roles have been experienced healthcare professionals, drawn from other parts of the existing workforce. If role design is to do more than simply transfer staffing shortages from one part of the system to another, the new practitioners must also be recruited from outside the NHS. But little is known about training direct entrants to carry out specialised surgical tasks.

A subtler issue relates to professional expertise. Much routine operative and perioperative practice is repetitive and underpinned by clinical protocols. Practitioners in new roles have much to offer in this area. But beyond the boundaries of the routine, when clinical presentations are atypical and confusing, the skills of experienced consultants are essential. Such wide ranging expertise takes years to acquire and, although easily recognised, is hard to define.[9] Yet if surgical practice becomes dominated by narrowly defined roles, future generations of surgeons may lose the mature expertise that allows them to recognise and manage difficult clinical challenges. If that happened we would lose something very valuable.

We believe that practitioners in new roles can be effective in selected surgical settings and can offer noteworthy benefits. Opponents, however, fear a diminution in training opportunities for doctors and see a threat to established lines of clinical responsibility. In our view, the solution is not to oppose the development of practitioners in new roles, for they offer great potential in a rapidly changing health service. Rather we should support what such roles can offer by ensuring that they meet the highest clinical standards. For this to succeed, practitioners in new roles need to be part of a wider national framework, where high quality care delivered by medically unqualified practitioners is combined with the best elements of traditional consultant led surgical practice.

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