Summary box

Most people with chronic illnesses are never seen by a specialist

The specialist should have a key role in improving quality of care outside the clinic

This requires more effective bridging of the primary-specialist interface for people with chronic illness

Stepped care protocols can incorporate appropriate use of specialist expertise

patient. Joint consultations would serve an educational as well as clinical purpose[13] and could even replace the majority of traditional outpatient appointments. A specialist who values this way of working told me:

In this setting, because the doc and the nurse know the patient inside out, they can bring me up to speed really quickly, I can then go in and get to the meat of what matters to the patient very early. We can also work out a whole series of things they might try, and so often what I try and end up doing is laying out some options for a variety of things over the next six months. So the patients often feel as if they get a lot out of it and the primary care team feels as if they've been supported. They've got several things they can try and they're still in control.—specialist in health maintenance organisation

The consultant has an educational role through regular meetings with staff at all levels. These meetings should provide supervision and support but also build mutual trust by acknowledging that the consultant has a lot to learn about primary care. The consultant should also take the lead in improving quality of care and getting the processes in place.[16] System change takes time, diplomatic skills, effective communication, and good working relationships. Primary care teams have to adapt to having a new member, and successful collaboration requires patience and humility. People I spoke to at all levels of the care process identified various qualities required by consultants (box 2).

Conclusions

Consultants have a key role in chronic disease management as part of the extended care team. They are well placed to collaborate in designing stepped care protocols, provide decision support and consultation to nurse specialists and primary care providers, and specialist interventions to patients with complex needs. Above all, they have a leadership role in bringing about innovation and change.

This paper is based on detailed observations, interviews, and discussions with primary care physicians and specialists across the United States during a Harkness fellowship in healthcare policy and practice supported by the Commonwealth Fund of New York and based at the Center for Health Studies, Group Health Cooperative, Washington, USA. These were informed by a Medline search of the literature using combinations of the free text search terms: specialist, consultant, chronic disease, stepped-care, and integrated. Martin Roland provided helpful comments on an earlier draft.

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Corrections and clarifications

Abstinence only programmes do not change sexual behaviour, Texas study shows
During the editorial process two errors crept into this article by Janice Hopkins Tanne (*BMJ* 2005;330:326, 12 Feb). We wrongly said that Doug McBride, a spokesman for the Texas Department of State Health Services, was also an author of the Texas study reported in the article. We also said the evaluation of the programmes was prompted after Democratic Senator Henry Waxman and others complained that 11 of the 13 commonly used programmes included false and misleading statements; in fact, the evaluation programme was already under way before Senator Waxman reviewed the programmes and said he found errors.

Association between suicide attempts and selective serotonin reuptake inhibitors: systematic review of randomised controlled trials
The authors of this paper, Dean Fergusson and colleagues (*BMJ* 2005;330:396-9, 19 Feb), have notified us of some incorrect values in the Results section (fourth paragraph of print version and sixth paragraph of full version). The odds ratio of fatal suicide attempts for selective serotonin reuptake inhibitors compared with tricyclic antidepressants should be 1.08 (0.28 to 4.09) (not 7.27 (1.26 to 42.03) as reported). They state that this does not affect the main conclusions or the main message of the article.

Obituary: Alfred Ian Douglas Prentice
In this obituary by J B Enticknap (*BMJ* 2005;330:542, 5 Mar) we were quite clearly mistaken in saying that Dr Alfred Ian Douglas Prentice died in August 2005; he died in August 2004.