Workload

Microbiology workload

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Changing the culture for microbiology consultants?

All doctors complain about their workload. In particular, the growing non-clinical component is seen not only to distance us from our "real job" but also to draw us into that miserable vortex of irrelevant targets proscribed by faceless bureaucrats, to be achieved with ever diminishing resources. Sound familiar? But is it true? Or is some of this self inflicted? Are we our own worst enemies? The interesting article by Riordan and colleagues¹ deals with these issues.

Microbiologists have certainly as much, if not more, reason to complain than most. Various government initiatives have expanded, permanently or temporarily, clinical services, especially surgery, but without concomitant microbiological expansion. Lord Moynihan had it right when he aphorised that "every surgical incision is an adventure in bacteriology". Like foreign holidays, many of these adventures have had unintended microbiological complications. Added to these the government's belated discoveries of the clinical (and economic) consequences of nosocomial infection, antibiotic resistance, hospital cleanliness and hygiene, and so on have made the microbiologist's telephone become very busy indeed. Worse, targeted demands from on (very) high to curb all these problems have landed on chief executives' desks and proceeded to the consultant microbiologists' desks with the speed of light, but not the means of illumination. Arguably, therefore, consultant microbiologists can fairly claim to be overburdened if all this is to be added to their previous clinical and laboratory duties without any extra resource.

However, even if there has been little change in the number of consultants (or, at least, not a change commensurate with the increased need), other things

have changed. There are more infection control nurses and the increase is not simply in numbers, it is also in competence and skill. Similarly, biomedical scientists and clinical scientists have many additional skills and roles compared with even a short time ago. Laboratory computer systems are widely available and increasingly capable of taking over many mundane aspects of reporting and authorisation of results, using rule based programmes. How should these and other innovations be set against the new burdens on consultants?

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Riordan and colleagues are refreshingly honest in their audit of their work.¹ They frequently admit that they do not necessarily work in the most logical manner and do not always take best advantage of some of the new help available. On some of these occasions their "illogical" approach is specifically designed to maintain and foster links with ward based clinical colleagues and one is forced to agree that this intangible price might well be worth paying, but other examples have no such excuse and they suggest some actions to deal with these.

A particularly important finding was that consultant microbiologists' time cannot be predicted by specimen load. Although obvious to many of us (after all, consultations and advice are not always to do with specimens), it is vital that everyone, including the profession's

own supporters, understands that simple fact.

The good news is that they managed to produce a consensus (involving, no doubt, considerable changes for some of them) of the needs and, within them, the priority of tasks to be done by consultant microbiologists. This outcome provided a more rational approach to workload control and made better use of the other staff and equipment. The bad news is that, even so, most of the respondents will still be working over 48 hours each week, excluding on call activities.

Therefore, there is still a strong case for more support. Indeed, one hopes that it is even stronger because these microbiologists now have a ready answer to the assertion that they are not necessarily making the best use of existing resources. Similar studies need to be done elsewhere for different models of microbiology service provision. All of the participants in this study were Public Health Laboratory Service (PHLS) consultants working in PHLS laboratories. One suspects that similar forces will be at work in National Health Service and university clinical laboratories, but there may well be important differences too.

Following the recent publication of the chief medical officer's report,² all models of microbiological service provision will be up for re-examination. Although this report was not primarily intended to address the issues considered by Riordan and colleagues,¹ their study informs this debate and is, therefore, very timely.

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