Audit on the role of the eating disorder psychiatrist

Erica Cini[1,2,3,†], Nargis Rahmanfard[1,†], Nelly Wright[1,4], Rena Jobanputra[5], Isabel Graham[1], Sarah Boughetane[1], Dasha Nicholls[6]

1. East London NHS Foundation Trust, London, UK
2. King's College London, London, UK
3. University College London, London, UK
4. Hertfordshire Partnership University NHS Foundation Trust, Hatfield, UK
5. Guy's and St Thomas' NHS Foundation Trust, London, UK
6. Imperial College London, London, UK

† Joint lead authors

✉ Corresponding authors: Erica Cini. Email: erica.1.cini@kcl.ac.uk; Nargis Rahmanfard. Email: nargis.rahmanfard1@nhs.net

Abstract

Consultant eating disorder (ED) psychiatrists play a lead role among the multidisciplinary team within ED services, as their skill set equips them to manage these complex disorders effectively using a multidimensional approach.

The aim of this audit was to determine the degree of alignment of consultant ED psychiatrist roles with the 2014 Royal College of Psychiatrists guidelines (1), focusing on clinical work, leadership and educational responsibilities. Fifteen consultant ED psychiatrists were interviewed and their self-reported roles were compared to the guideline set by the Royal College.

The data showed that clinical responsibilities were the most consistently performed (100%), while educational roles, specifically external education, were least represented (13.3%). Leadership responsibilities, mainly service development, were also prominent (80.0%) but some psychiatrists reported insufficient time for other responsibilities, such as therapeutic work and training. No psychiatrist was able to fulfil all of the roles described in the 2014 guidelines. This audit highlights the differences between Royal College expectations and current practice, emphasising the importance of further investment in consultant ED psychiatry to enhance service delivery.

Introduction

Consultant psychiatrists working in eating disorder (ED) services form an integral part of the multidisciplinary team needed to manage these multidimensional disorders. Eating disorders have a complex presentation of psychological and physical symptoms, and the breadth of the medical and psychiatric skills that consultant ED psychiatrists possess means they are able to offer a holistic and well-rounded oversight of the treatment of these disorders.

This audit aims to investigate the adherence of the consultant ED psychiatrist role to the "gold standard" described in 2014 by the Royal College of Psychiatrists (1), based on interviews with current ED psychiatrists. According to the Royal College, consultant ED psychiatrists are expected to provide clinical care, leadership and educational roles in their positions.

Methodology

The self-reported roles and responsibilities of consultant ED psychiatrists were compared with those described by the Royal College in a 2014 statement (1) and later established as the national standard necessary for psychiatrists working in ED services.

The audit was advertised via the Faculty of Eating Disorders Royal College Network and the online community EDSIG (the Eating Disorder Special Interest Group) mailing list, inviting consultant ED psychiatrists to participate. Ultimately, 15 consultants from across the UK took part in semi-structured telephone interviews conducted between 14 July and 8 September 2018. Interviews were conducted by one of the authors (EC) and transcribed concurrently. The participants worked across the age groups, with seven psychiatrists working in child and adolescent services and eight working in adult services. Verbal consent to participate was given by each interviewee.

As this was an audit requested by the Royal College and not clinical research, ethics approval was not required. Interviews were not qualitatively analysed as this falls outside the scope of the audit.

Three main domains were identified within the role and subcategories, which are outlined in the results (see Table 1). Interview notes were cross referenced against Royal College roles by four of the authors (NR, NW, IG and SB) and then crosschecked by one author (NR).

Category	Role	No. engaging in role (N = 15)	%
Clinical	Psychiatric, medical and risk assessments	15	100.0
	Liason with other services	8	53.3
	Clinical supervision	8	53.3
	Delivering psychological therapy	5	33.3
Educational	Staff training	5	33.3
	External education around eating disorders	2	13.3
	Supporting trainees	5	33.3
Leadership	Maintenance and development of services, service leadership/service development	12	80.0
	Lead in audit and standards	4	26.7
	Supporting team in case management, e.g., in multidisiplinary teams (clinical leadership)	10	66.7
Research	Engaging in research	3	20.0

Table 1. Reporting on the fulfilment of roles by consultant eating disorder psychiatrists

Results

The subcategories identified showed that consultant ED psychiatrists cover a wide range of responsibilities. Clinical aspects of their role were better represented than other aspects. It was also noted that research and educational opportunities, specifically external ED education, were the least practiced areas within their job plan.

The most represented roles were psychiatric, medical and risk assessments (n = 15, 100.0%); maintenance and development of services, service leadership and service development (n = 12, 80.0%); and supporting their teams in case management (n = 10, 66.7%).

Conducting clinical assessments was the only category identified by all interviewees, highlighting how integral this is to their role. Liaison with other services was referenced by just over half of those interviewed.

Despite psychiatrists learning to deliver psychological therapies during core training, and some even receiving additional training in therapy afterward, few psychiatrists had the opportunity to deliver therapeutic interventions. The gold standard itself does not clarify which therapeutic interventions would be offered in an ED context, although family therapy (n = 6, 40%) and cognitive behavioural therapy (n = 7, 46.7%) training were commonly mentioned by participants. Therapy intervention was the most poorly represented of the clinical roles (n = 5, 33.3%).

"I don't think it is cost-effective to use me as a therapist." (Participant 3)

"The way the service is set up, none of the psychiatrists have the opportunity to practice these [therapeutic] skills." (Participant 8)

Those who did not provide therapeutic interventions reported conflicts within their roles or time constraints as barriers to this.

Training roles within the ED teams and wider NHS trust were poorly represented in the sample, with only one-third mentioning roles in staff training or supporting trainees. This lack was noticed by those interviewed, with multiple psychiatrists highlighting the absence of an ED training pathway.

"There are no trainees, and they would struggle to recruit as there is no training program for [the] eating disorder specialty." (Participant 6)

Providing education on EDs to a wider community setting was detailed in the Royal College document (1) but mentioned by only two of the psychiatrists interviewed (13.3%), making it the most poorly represented aspect.

Most consultant psychiatrists (n = 12, 80%) did take a lead role in the services, with some expressing dissatisfaction specifically with managerial responsibility. In some services, consultant ED psychiatrists were expected to lead on clinical work and focus on direct patient care but were unfortunately not empowered to take service leadership roles. Others referenced being involved in commissioning groups and having input in the wider management of their organisations. The necessity of attending managerial meetings was also highlighted as a barrier to other activities.

"Consultant psychiatrists are trained for leadership and service development which should include QI [quality improvement], staff development and sometimes research and teaching." (Participant 3)

Discussion

By capturing the day-to-day role of a varied group of consultant ED psychiatrists, this audit has highlighted the gap between the reality of the role and what the Royal College document (1) has outlined that the role should be. Despite their holistic training, the current audit suggests that consultant ED psychiatrists mainly contribute to clinical work, in

particular assessment, formulation and diagnosis, as well as leadership and team management activities.

The clinical time of consultant ED psychiatrists is spent on physical care and risk management of patients, with this being prioritised over other clinical tasks, such as therapeutic interventions. Some psychiatrists identified a lack of funding for full-time psychiatry posts, which could put services at risk in the long term and, in turn, lead to a devaluing and erosion of the role, to the detriment of patient care.

The role that psychiatrists provide in maintaining their services, through recruitment, attending managerial meetings and securing funding, is an essential aspect of specialist ED services continuing. However, some who were interviewed identified a lack of protected time for this, which added pressure to their job plan. It would be helpful to see NHS trusts valuing their input by ensuring that such clinical leadership and strategic roles are accounted for in the psychiatrist job plan.

The Royal College of Psychiatrists sets out the expectation that consultant psychiatrists in all specialties will be up to date on evidence-based approaches and will contribute to knowledge development by supporting research. This audit shows that engagement in research is not currently being actualised within ED services, which may inhibit the development of new evidence-based approaches.

In conclusion, this audit identified clear gaps in the provision of psychiatry across services. There is a need to consider how this role could be further actualised and developed in response to this. For example, an increase in psychiatry recruitment and retention, both in terms of increasing the interest of doctors in specialising in psychiatry and improving the training pathway for the ED specialty. The authors acknowledge that this means additional investment, however, consultant expertise improves service quality and adds to the effectiveness of the multidisciplinary team. Despite the financial pressures that the NHS is facing, service providers should not underestimate the importance of recruiting consultant psychiatrists who add value to ED teams across the various domains.

Further research that may be beneficial in this area could include an analysis of how many consultant ED psychiatry roles are currently in place or open in the NHS, as well as a more thorough analysis of the current compared with potential training pathways for this subspeciality.

Author contributions

EC: audit conception and design, data collection, manuscript preparation and critical comments. NR: manuscript preparation and critical comments. NW: manuscript preparation and critical comments. RJ: manuscript preparation. IG: manuscript preparation. SB: manuscript preparation. DN: audit conception and design, data collection, manuscript preparation and critical comments.

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