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Editorial

The Risks of Non-Medical Professionals Holding Medical Consultant Responsibility for Hospital Inpatients

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1. Initiative to Appoint Non-Medical Consultant-in-Charge for Inpatients

In recent years, some National Health Service (NHS) Trusts have appointed non-medically trained professionals to consultant-in-charge roles with responsibility for inpatient rehabilitation beds [1]. These appointments have largely been driven by workforce shortages within financially constrained and overstretched services. Individuals appointed to these roles come from a range of professional backgrounds, including nursing, psychology, physiotherapy and occupational therapy, and some have been granted patient admitting rights. Some are also expected to oversee the management of patients' medical complications during their inpatient stay. Although these roles are said to operate under the supervision of medically qualified staff, such arrangements raise significant concerns regarding patient safety, professional accountability, and the clarity of clinical responsibility.

As the UK's professional body representing rehabilitation physicians, the British Society of Physical and Rehabilitation Medicine (BSPRM) states unequivocally that it firmly opposes the appointment of non-medical professionals to consultant roles with overall responsibility for inpatient hospital care [1]. We, as members who led the writing of this position statement, present here a detailed reasoning behind our members' reservations and our concerns regarding this policy.

2. Patient Safety Must Always Come First

Medical consultants undertake many years of formal post-graduate training in order to manage diagnostic uncertainty, multimorbidity, and clinical risk. Irrespective of their baseline medical complexity, hospital inpatients remain vulnerable to diagnostically challenging and often serious complications, many of which deteriorate unpredictably and rapidly; early recognition and timely intervention are essential to preventing avoidable harm. Patient safety is compromised when diagnoses are missed, proper treatment is delayed, and unusual outcomes are not recognised.

To take but one example, the sudden onset of breathlessness and chest discomfort in a patient with reduced mobility may be passed off as a cold or chest infection, whereas this may represent an evolving life-threatening pulmonary embolism (PE), which demands urgent assessment and treatment. The ability to recognise subtle or atypical presentations of critical illness, in this case PE, but in other instances a silent myocardial infarction, or worsening hydrocephalus or endocrine dysregulation in patients with acquired brain injury, relies on extensive medical training and years of experience across acute clinical settings.

Professionals without medical training may argue that patients in inpatient rehabilitation are "not acute" and are therefore comparable to patients managed at home. However, this overlooks the fundamental fact that hospital admission itself confers additional, well-recognised risks, including healthcare-associated infection and hospital-associated thromboembolism, alongside other in-hospital harms related to immobility and inpatient care processes [2].

Healthcare systems and departments have a duty to minimise the risk of even a single critical incident wherever possible. This obligation dictates that only medically trained professionals on the General Medical Council (GMC)'s specialist register should hold admitting rights for inpatient rehabilitation beds, regardless of perceived patient complexity or clinical stability [3,4]. Similarly, only medically trained professionals on the GMC's specialist register should be responsible for medical decision making during a patients' admission.

3. The Policy to Introduce Non-Medical Consultants for Inpatient Medical Care Worsens Disability Injustice

This approach implicitly suggests that individuals with complex disabilities are not entitled to the same level of medical oversight routinely afforded to non-disabled pa-

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tients in other clinical specialties. The appointment of non-medical professionals as inpatient consultants has no parallel in acute specialities such as medical assessment units, critical care, neurosciences, or orthopaedics.

If left unchallenged, the adoption of this policy risks repeated institutional failures and exposes disabled patients to avoidable harm. Comparable patterns have already been documented in areas including learning disability services [5] and maternity care [6], where insufficient medical leadership has been associated with substandard care and serious adverse outcomes.

4. Rehabilitation Is Inherently Multidisciplinary

We fully support clearly defined non-medical specialist roles, including specialist nurses and therapists, who deliver essential components of inpatient rehabilitation. There is strong evidence that multidisciplinary care achieves better outcomes than medical care delivered in isolation, particularly within rehabilitation services [7].

However, ultimate responsibility for medical care must in every instance remain with a medical consultant. Excluding rehabilitation physicians from inpatient rehabilitation pathways deprives patients—especially those with complex needs—of access to physicians who are fully trained in the management of their diagnostic, medical, surgical and ultimately functional challenges. Financial efficiencies should never be pursued at the expense of patient safety or quality of care.

Furthermore, this approach is inconsistent with the recent World Health Assembly resolution, which calls for sustained investment in comprehensive rehabilitation workforces across all disciplines, including medical specialists [8].

5. We Must Not Blur Professional Boundaries

Even though "rehabilitation" may sound multidisciplinary and non-medical to many hospital physicians, there is a defined role for a physician working in this field. Appointing non-medical professionals to consultant physician roles with responsibility for inpatient care creates ambiguity for patients, families, and multidisciplinary teams regarding where ultimate medical responsibility lies. Unclear lines of authority, especially when recognising and managing medical emergencies, represent a significant clinical governance risk, particularly as inpatients may deteriorate rapidly. regardless of perceived medical stability.

The ill-defined and ambiguous role of a non-medical consultant raises serious questions regarding legal accountability in the event of fatal outcomes or near-miss incidents in the course of an inpatient admission. Without comprehensive medical training, no clinician can safely or effectively assume overall responsibility for medical decision-making; a non-medical professional simply does not possess the breadth nor depth of medical knowledge, diagnostic expertise, and clinical skills required for this role.

6. Becoming a GMC-Recognised Rehabilitation Consultant Requires More Than a Decade of Medical Training

Doctors undertake 3–5 years of medical residency (foundation and core training) and pass Royal College membership exams (such as Membership of the Royal College of Physicians (MRCP)) before entering a 4-year GMC-approved training programme in Rehabilitation Medicine [9]. This training includes rotations across multiple subspecialties and extensive experience in managing complex medical issues within rehabilitation settings.

Rehabilitation physicians are trained not only in diagnosis and management of new and evolving medical complications, but also to coordinate care with other specialties, make complex treatment and ceiling-of-care decisions, and provide long-term prognostic assessments related to disability. These trained physicians are needed for making innovations in medical aspects of care, which cannot be replaced by advances in non-medical professionals and Artificial Intelligence.

Replacing medical consultants with non-medical professionals who do not have equivalent training or Royal College accreditation undermines the value of this rigorous pathway and the expertise it produces. Moreover, substituting the medical workforce in rehabilitation risks diminishing the attractiveness of the specialty to future doctors, with potential long-term consequences for workforce quality and, ultimately, patient care.

7. Lack of Such a Policy in Other Countries

We are not aware of any other country in which non-medical professionals are granted overall responsibility as inpatient medical consultants. Permitting this practice in the NHS sets a concerning precedent for a system long recognised internationally for its safety and quality standards. The NHS is already facing significant workforce pressures among medically trained professionals, and policies that substitute these roles with non-medical staff risk exacerbating the crisis and undermining confidence in the UK's healthcare system.

8. Conclusion

BSPRM fully endorses advanced specialist practice roles for non-medical and allied health professionals as essential contributors to high-quality, multidisciplinary rehabilitation in hospital settings. However, these roles must function within a framework that preserves clear medical leadership and ensures accountability for patient safety and overall care lies with medically trained consultants.

Key Points

• The medical specialty of Rehabilitation Medicine (Physical and Rehabilitation Medicine) must be recognised, protected, and developed to ensure that patients with disabilities receive the highest standard of medical care.

• Assigning medical consultant responsibilities to non-medical professionals poses significant patient safety risks and raises substantial legal and ethical concerns across healthcare systems.

• Professional boundaries must remain clearly defined to avoid confusion for patients, and GMC-trained medical consultants must retain ultimate responsibility for all medical care provided to hospital inpatients.

• Leadership and accountability for medical decision-making must rest with medically trained consultants, irrespective of patient complexity or clinical stability, including those receiving care within rehabilitation pathways.

• Multidisciplinary care achieves optimal outcomes only when physicians within the team have completed the highest level of medical training and are not substituted for by non-medical professionals.

Availability of Data and Materials

Not applicable.

Author Contributions

MS, SA and JH designed the work. MS drafted the maunscript. All authors contributed to the important editorial changes in the manuscript. All authors read and approved the final manuscript. All authors have participated sufficiently in the work and agreed to be accountable for all aspects of the work.

Ethics Approval and Consent to Participate

Not applicable.

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Conflicts of Interest

The authors declare no conflicts of interest.

References

[1] BSPRM. BSPRM Position Statement on non-medical professionals taking on consultant responsibilities for inpatient rehabilitation beds. 2025. Available at: https://www.bsprm.org.uk/articles/bsprm-position-statement-on-non-medical-professionals-taking-on-consultant-responsibilities-for-inpatient-rehabilitation-beds/ (Accessed: 26 February 2026).

[2] UK Health Security Agency. Point prevalence survey on healthcareassociated infections, antimicrobial use and antimicrobial stewardship in England, 2023. London: UKHSA. 2025. Available at: https://assets.publishing.service.gov.uk/media/6827325d010c5c28d1c7e728/HCAI-AMU-PPS-2023-report.pdf (Accessed: 26 February 2026).

[3] GMC. About Good Medical Practice. 2024. Available at: https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice/about-good-medical-practice (Accessed: 26 February 2026).

[4] CP. Consultant physicians working with patients. 2013. Available at: https://www.scribd.com/document/671952970/Consultant-physicians-working-with-patients-revised-5th-edition-1 (Accessed: 26 February 2026).

[5] Ince R, Glasby J, Miller R, Glasby AM. 'Why are we stuck in hospital?' Understanding delayed hospital discharges for people with learning disabilities and/or autistic people in long-stay hospitals in the UK. Health & Social Care in the Community. 2022; 30: e3477–e3492. https://doi.org/10.1111/hsc.13964.

[6] Jakes AD, Watt-Coote I, Coleman M, Nelson-Piercy C. Obstetric medical care and training in the United Kingdom. Obstetric Medicine. 2017; 10: 40–42. https://doi.org/10.1177/1753495X16681201.

[7] Bachmann S, Finger C, Huss A, Egger M, Stuck AE, Clough-Gorr KM. Inpatient rehabilitation specifically designed for geriatric patients: systematic review and meta-analysis of randomised controlled trials. BMJ (Clinical Research Ed.). 2010; 340: c1718. https://doi.org/10.1136/bmj.c1718.

[8] WHO. Strengthening rehabilitation in health systems. 2023. Available at: https://apps.who.int/gb/ebwha/pdf_files/EB152/B152%2810%29-en.pdf (Accessed: 26 February 2026).

[9] GMC. Rehabilitation Medicine Curriculum. 2024. Available at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/curricula/rehabilitation-medicine-curriculum (Accessed: 26 February 2026).