TALKING POINTS

Multidisciplinary teams

JAMES APPLEYARD, J G MADEN

A patient still visits his doctor for treatment and expects the doctor to make the decisions on his illness. But doctors can and regularly do consult professional colleagues when care of the patient may require the help of paramedical, social, and educational experts. The General Medical Council has recognised this and in *Professional Conduct and Discipline*[1] it welcomed the growing contribution made to health care by nurses and others who have been trained to perform specialised functions. But the council believes that a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. The doctor must, however, retain ultimate responsibility for the management of his patients. If he delegates functions requiring the knowledge and skill of a medical practitioner to a person who does not possess them he is liable to disciplinary proceedings.

But from the acceptable multidisciplinary approach has grown the more formalised multidisciplinary team. The aim is to produce an agreed policy for a treatment programme. The decision, however, is made not by the doctor alone but by the team. This concept has become so attractive that it is now "the establishment's" answer to difficult clinical problems in the Health Service. Many recent reports from the Department of Health and Social Security extol the virtues of multidisciplinary teams and the Report of the Royal Commission on the NHS takes them for granted.[2]

We know of no evidence that the clinical decisions arrived at are any better than those taken by a responsible doctor after consultation with his colleagues. Indeed, we see the implications of the formalised system as serious for patients and for the medical profession. It is impossible for a team to carry out any form of treatment or social work with an individual patient. Most people prefer to deal with one person to whom they can relate professionally and personally. In other words, the hand that gives the pill is almost as important as the pill itself. The multidisciplinary team can never fulfil this task as it discusses the patient without his being present: indeed, sometimes not every member of a team has even seen the patient.

Conflict of interests

Problems arise when there is a conflict of professional interests. Even if a team reaches some sort of conclusion an individual member can sabotage the whole concept by doing nothing if he does not agree about the general needs of the patient. In my experience some of the most serious problems have arisen with social workers, clinical psychologists, and educational psychologists, who are not employed by the NHS. They have claimed that they are separate professional entities. Although members of the team they reserve the right to act independently as well. So they produce a dichotomy by inaction. Sometimes when they are asked to do something with which they do not agree they do not bother to do it or delay taking action for so long that it is ineffective.

Kent and Canterbury Hospital, Canterbury, Kent CT1 3NG
JAMES APPLEYARD, BM, MRCP, children's physician

Burnley General Hospital, Burnley, Lancs
J G MADEN, MRCS, LRCP, psychiatrist

There are several examples of this. One is the social worker in psychiatry. When the Seebohm proposals were introduced[3] with their concept of the generic social worker interpretations varied in different local authorities about whether the social workers should be generic or whether there should be generic area teams with social work specialties in each team. Initially there was a general move to make every social worker generic but now the pendulum has swung back so that some local authorities have a mixture of both at different levels. The mental welfare officer's responsibility, for example, was passed to the area team, which is run by a director of social services. The hospital medical social workers suffered a similar fate. This has meant that in the multidisciplinary team the social worker was no longer responsible either to a doctor in the team or to a doctor outside the team—that is, the mental health officer—but to the director of social services. Unfortunately, the doctor's relationship to the Mental Health Act was not altered or clearly defined. As a result, there are occasions when two doctors sign both halves of a Section 25 admission form and pass it to the local authority or the social worker in their team, or to the area team. Then the social worker in his own right as an employee of the local authority may visit the patient, decide that there is no need for him to be admitted on a Section 25 procedure, and refuse to make the application.

This did not happen previously because the social worker was responsible to the medical health officer or to a doctor, a relationship that was the aim of the 1959 Mental Health Act. At no time was it intended that the mental welfare officer should act independently of medical advice, either negatively or positively. The doctor is finally responsible for deciding the patient's status on admission. A patient admitted informally, who should really have been admitted under a Section 25 procedure, could create havoc on the ward and cause stress and anxiety to the nurses. Although the social worker may make a recommendation before admission that in his view the patient does not need an order, from the medical and nursing point of view such an order may be necessary. The doctor and the nurse, not the social worker, are left with the problem, and the whole process of certifying the patient has to begin in hospital via a Section 30 procedure. It would have been better for the doctor, who knows the type of illness and the type of patient, to be consulted and the admission done on a formal order.

Clinical psychologists

Clinical psychologists are professionals in their own right and, unlike other people such as pharmacists or chief technicians, they are responsible to the chief administrator, not to any medical authority. We have known instances where a psychiatrist and a psychologist have been treating an NHS patient for a similar condition in different ways at the same time. Decisions on the special education of disturbed children are taken by the community physician and the child psychiatrist and the final decision is left with the principal educational psychologist. Here again the psychiatrist working in a child guidance clinic, or a family and child psychiatry unit, and the paediatrician have lost their clinical authority. If the educational psychologist does not agree with the team's recommendation delays occur and the patient suffers. Some principal educational psychologists have been given a dual appointment as assistant director and

this can mean that the child's clinical needs become secondary to the financial policy of the educational department. As a member of the team the doctor will be seen as having been party to this policy; this occurs particularly with referrals to special schools.

So as we see it the multidisciplinary team completely undermines the concept of the registered medical practitioner. The General Medical Council has stated that if a registered medical practitioner has to delegate work to unregistered practitioners he must have control over these people. The doctor has no control over the educational psychologist, the clinical psychologist, or the social worker. He does not employ them nor, except in the case of the clinical psychologist, are they employed by the same authority. None of them has a recognised disciplinary professional body and therefore there are no ethical standards that can be enforced on individual members. There is, for instance, no control over the confidentiality of material. Furthermore, the doctor has no authority over an individual member of the team who wishes to give contrary advice to a client or patient.

Wider implications

The multidisciplinary team has even wider implications, which have been illustrated clearly in recent reports. The Inskip Committee of Inquiry at St Augustine's Hospital[4] proposed a complex multidisciplinary framework for the hospital based on a ward team. The report was accepted by the then Secretary of State, Mr David Ennals, and distributed to RHAs. Inskip proposed that the ward team should be composed of six members, two of whom—the consultant and the charge nurse or ward sister—were singled out to be chosen by colleagues and by ward staff. Though this may be attractive to those who believe in "democracy" in the Health Service, it is strange that the report should have required only two members of the team to be so selected. A principle, however, has been established whereby a doctor is elected by his colleague rather than chosen by the patient and selected for his own professional skills. The committee also recommended the takeover of the doctor's clinical functions by the ward team. The ward team would have corporate responsibility to the clinical area team for co-ordinating the formulation of policies and standards to be agreed by all disciplines. These included policies for admission to the ward and for management in the first 24 hours, a discharge policy, and principles governing medication and physical treatment, such as electric convulsion therapy.

Previously, the admission and discharge of a patient had been the ultimate responsibility of the consultant under whose clinical care the patient had been admitted. The management, medication, and treatment affecting a patient is at present the particular responsibility of the doctor. Indeed, the doctor is the only member of the hospital under the present law who is trained to take responsibility for the prescription of scheduled drugs. Inskip has introduced the concept of "corporate responsibility," by which he meant agreement by consensus and not because one profession had authority over the others.

In clinical matters this is an entirely new departure—members of the team with little or no training in pharmacology and therapeutics being able to overrule the decision of the doctor. Inskip also urged tighter clinical control of the ward team so that the policies and standards agreed between disciplines at ward level should be consistent with guidance given by a higher authority and should be submitted to the clinical area team for approval. If the ward team was unable to reach agreement Inskip recommended that the matter should be referred to the clinical area team for guidance. If that team could not agree the problem should be referred to the hospital management team. We see this as clinical direction by the hospital authorities—a dangerous development. Thus under Inskip's proposals an entirely new hierarchical "democratic" structure of teams and committees has been created, all charged with clinical authority. If this was fully implemented the doctor's clinical independence would be lost. He would be subject not only to consensus decision making but also to direction from higher teams and committees.

Review of the Mental Health Act

In the DHSS's *Review of the Mental Health Act 1959*[5] the same theme gets a new twist. The review recommended that a second opinion had to be sought for certain categories of treatment of psychiatric patients and that this opinion should be given by a multidisciplinary panel especially established for the purpose. The Labour Government believed that the establishment of such panels with substantial "medical involvement" would bring positive advantages and proposed that arrangements should be made for them to be set up. That government proposed that having sought the opinion of the panel a doctor would not be permitted to impose treatment except with the panel's endorsement. The seeking of a second medical opinion is well established but the proposal of placing a multidisciplinary team above the medical authority of the doctors destroys this concept. Not surprisingly, the proposal has been resisted by the Joint Consultants Committee, which hopes that the new government will not introduce it.

The Inner London Education Authority has published an interesting document on leadership in child guidance units.[6] This emphasises that the skills required for the proper performance of the units stems from clinical experience. It is then recommended that in future the unit's leader need not be a clinician, though the existing medical directors would be invited to do the job of the team co-ordinator for the time being. It is further recommended that the principal senior psychiatric social worker should be the recognised channel for formal communication with the medical department of County Hall. This would remove from the doctor his duty of controlling patients' clinical information and its presentation to the medical authorities. Furthermore, it would be the social worker and not the doctor who would be responsible for screening the referrals to the unit. This confusion of thought in the ILEA document highlights another dilemma of the multidisciplinary team. ILEA emphasises that all the professions that make up a child guidance team are responsible for their own judgment and action in relation to any case with which they are concerned. This principle of individual professional responsibility, the document continues, needs to be balanced by a statement on the nature of teamwork. It has defined this as follows: the members of the team collaborate as equals and are dependent on one another in providing a comprehensive service to their client; they accept that this inevitably entails a restriction on their freedom to act individually; they are aware of and accept the limits of their professional competence and are prepared to consult with their colleagues in other disciplines whenever necessary.

ILEA states that this should be clearly understood and accepted by new professional staff on appointment. So far as is practicable, the existing "team" should participate in the selection of new staff, at least on an informal basis and in an interdisciplinary way. There is a clear statement that doctors are equal members of a clinical team and so have no special clinical responsibility for the individual child. With many of the transferred child psychiatrists now seeking consultant status, ILEA's method of selection of new consultant staff is contrary to the existing advisory appointments committee procedure agreed between the departments and the profession.

In our view the clinical co-ordination of child guidance units should remain in the hands of the clinician. The most highly trained and experienced person is the child psychiatrist. He is able to judge which children referred to the unit are "reacting" in one way or another unfavourably to the stresses of the total environment or who are classified "mentally" ill. This is often a more difficult decision than that of dealing with the problems

themselves. The ILEA document suggests that one member of the "core team" should be nominated as the "leader" responsible for co-ordinating his colleague's activities. This makes nonsense of the core team co-ordinator and is dangerous if the non-medical "lead" member has a higher authority than the consultant child psychiatrist. The medical profession should not bow to this committee-style direction on clinical decisions.

Court Report

The Court Report on the future of child health services[7] fell into the final trap created by the multidisciplinary team concept. Court recommended that each health district should have a special multidisciplinary handicap team based on the district general hospital working from the child development centre. The clinical functions include investigating and assessing children with complex disorders and arranging and co-ordinating their treatment. The operational function includes monitoring the effectiveness of the district service for handicapped children and maintaining the quality of the district's institutions. As in child psychiatry, it is important that there is an identifiable person responsible for the handicapped child's care and that he should be the most highly trained member—namely, the consultant. The team concept does not achieve this, but even more alarming is the mixing of clinical and operational functions. So far as we know this is an entirely new departure from established medical management and it opens the door to administrative control of the individual patient.

After the public outcry about battered babies the Health Departments created a web of district and area multidisciplinary committees and case conferences. These have had the effect of removing the responsibility and therefore the blame from any one individual. Though the publicity has died down, there has been no firm evidence that this multidisciplinary system has been any more effective in coping with the problem. Indeed, our impression is that it has given rise to greater difficulties. Instead of the case conference teams consisting of differing "professionals" individual members have specific statutory responsibilities, which they should carry out despite what the majority of the team may think. Furthermore, there is the uneasy association between the clinician responsible to the individual child and the police who are responsible for enforcing the law. More depends on the personalities of those concerned than the formal system so clumsily designed to deal with these tragic problems.

We are in no doubt that the multidisciplinary system has eroded clinical care in geriatric medicine, in psychiatry, and, increasingly, in paediatrics. The acute specialties have always considered themselves immune to this damaging development. But increasing pressure is being put on the general practitioner and we forecast that before long social workers or health visitors may be suggested as "lead" members of the team and would sift patients before they are reviewed by the primary health care teams. A paediatrician at Northwick Park Hospital has promoted the policy that when more than one child on an acute paediatric ward has diarrhoea, a multidisciplinary conference, consisting of the paediatricians and representatives of the nursing and ancillary staff, the district community physician, the consultant bacteriologist, and the control of infection officer, should meet to consider the management.[8] This implies that paediatricians can no longer be trusted with the clinical management of their children on the ward.

The Health Service cannot afford an extensive multidisciplinary framework. At peripheral hospitals clinical decisions have to be taken quickly and the judicious use of the telephone makes the expense of a case conference unnecessary. If the multidisciplinary bandwagon rolls on doctors will lose their clinical responsibility and independence and patients will find themselves queueing—even longer than now—for their treatment to be undertaken by committees.

References

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Setting up an action group: advice from an "activist"

NORMAN BURNS

Public backing, informed speeches, support from all political parties, and the co-operation of CHCs and local media are all essential ingredients for a successful action group. If the aim is to get an increased share of an inadequate cake the pressure will have to be sustained for a long time.

The Nottinghamshire AHA has had to cut back its budget by £3 million. This means that in 1979-80 there will not be sufficient money in Central Nottinghamshire even for urgent maintenance of hospital buildings or equipment. The cuts also mean that apart from hospital closures there will be a freeze on most vacancies for three months, no new district nurses or health visitors, elimination of overtime, stricter control over budgets, reduction in the number of operations, and a delay in the new district general hospital. So at the beginning of this year we formed the Central Nottinghamshire Health Finance Action Group after a meeting sponsored by the local community health council and another of the staff side of the joint staff consultative committee, which had sought to discuss the cuts with the AHA, had met with rebuffs from the administration.

Faced with such an uphill task the group, with the hard work and enthusiasm of all its members, has certainly made the public aware of the cuts' consequences. Last month, after several signature-collecting days for a petition, a local day of protest was held and the petition presented to the AHA.

Mansfield, Notts
NORMAN BURNS, MB, MRCGP, general practitioner and chairman of the Central Nottinghamshire Health Finance Action Group

Well advertised, well organised

The first public meeting of a group like this must be well advertised and well organised and in Central Nottinghamshire the CHC had been publicising the issues in the local newspapers for some time. The group's title is important and if possible