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Multi-disciplinary Clinical Teams

Ivor Batchelor
Jean McFarlane

Based on working papers of the Royal Commission on the NHS

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MULTI–DISCIPLINARY CLINICAL TEAMS

by

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Secretariat of the Royal Commission on the NHS

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CONTENTS

4

EDITOR'S INTRODUCTION

The development of multi-disciplinary working in the administrative and clinical settings received much comment in the evidence submitted to the Royal Commission on the National Health Service. A discussion of the issues involved in multi-disciplinary clinical working is included in the Royal Commission's Report *. The papers reproduced here served as background material to the Commission's deliverations on the subject. The first paper is a summary of the issues involved, written by the Secretariat of the Commission. The second is a paper prepared for the Commission by Professor Ivor Batchelor, a member of the Commission, who as a professor of psychiatry has had much experience of the multi-disciplinary approach in clinical psychiatry. The third paper provides a nursing view of the multi-disciplinary clinical team from another member, Professor Baroness Jean McFarlane, professor of nursing at Manchester University. The views expressed here do not necessarily reflect those of the King's Fund or the Royal Commission.

This is the twelfth in a series of project papers based on the working papers of the Royal Commission on the NHS. We are grateful to King Edward's Hospital Fund for London for giving us a grant to enable this series to be produced and to the Plytechnic of North London where this project has been based.

Christine Farrell
Rosemary Davies

* GREAT BRITAIN, PARLIAMENT *Report of the Royal Commission on the NHS* (Chairman Sir Alec Merrison) London, H M Stationery Office, 1979. paras 138–142 *Cmnd 7615*

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Christine Farrell

Rosemary Davies

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1978. pages 138–142 Cmnd 7215

MULTI-DISCIPLINARY CLINICAL TEAMS

The Secretariat of the Royal Commission on the NHS

HISTORY AND DEVELOPMENT

The development of multi-disciplinary clinical teams (MDCTs) has been gradual over many years. The earliest developments in multi-disciplinary working were in psychiatric hospitals and in the fields of child psychiatry, child guidance and mental handicap. In acute hospital care the operating theatre team is cited as an early example. Early developments in this field are thought to have been precipitated by 'high technology' medicine and the introduction of intensive care units. The growth in the number of health centres, and the government's acceptance in 1966 of the partial reimbursement of the salaries of ancillary staff employed by general practitioners, are identified as factors which encouraged the development of multi-disciplinary working in primary care. In all areas of health care delivery the development of professional skills, ethical standards, roles in relation to treatment and of specialised forms of treatment and management are identified as contributing to the growth of multi-disciplinary working.

Specific guidance on multi-disciplinary clinical teams has not been issued by health departments although certain Departmental publications are identified as providing broad guidance and/or encouragement. A list of these references is at Appendix A. The majority of them simply emphasise the need for a multi-disciplinary approach in the treatment of specific client groups. A literature search on multi-disciplinary clinical teams is at Appendix B.

DEFINITIONS

The term MDCT is used to describe the group of NHS and other workers who are contributing to a patient's (or client's) health or care. The MDCT is to be distinguished from the multi-disciplinary teams referred to

in the literature of NHS reorganisation whose function is the coordination and planning of services provided for groups of patients. The members of the MDCT are, by contrast, bringing their skills to bear on the care and treatment of an individual patient.

Because the MDCT is dealing with individual patients ('patient' is used to include the clients of a social worker where appropriate in the rest of this paper) its membership will of course reflect the needs of the particular individual, and there are any number of different combinations of members of the teams according to whether the patient is being looked after in hospital or in the community and what is wrong with him. For example, the team caring for a mentally ill person in hospital might consist of a psychiatrist, nurse, psychologist, social worker and occupational therapist; that caring for a stroke patient in the community, might consist of a GP, community nurse, home help, physiotherapist and speech therapist; and that concerned with the patient in a surgical ward, might consist of a surgeon, anaesthetist, radiologist and nursing staff. Depending on the circumstances MDCTs may also include medical specialists of different kinds, or perhaps a remedial gymnast, laboratory technician, hospital administrator, domestic supervisor, chiropodist, teacher, pharmacist (particularly in the primary care team) and even relatives and voluntary workers. Obviously there will be a good deal of resemblance between MDCTs dealing with patients with similar illnesses or disabilities in similar circumstances. It is, however, important to remember that no two patients' needs will necessarily be the same and this diversity will be reflected in the skills of the workers involved.

PROBLEMS

The MDCT may be seen as little more than a convenient shorthand to describe a group of colleagues with a common involvement in the care and/or treatment of a particular patient. However, this may be a case where terminology is misleading or positively damaging: the word 'team' which is generally used to describe this group, implies a degree of formality and permanence which the realities of the

situation do not justify. Teams have captains and vice-captains and perhaps a bureaucracy to arrange their fixtures. Whatever the reason, a number of problems were identified in the evidence to the Royal Commission bearing on this situation. They include:-

(a) the leadership of the MDCT;

(b) the nature of the corporate responsibility of the team and its effect on the individual members responsibility;

(c) confidentiality and communications;

(d) legal aspects of these matters;

(e) the particular problems of the primary care teams.

These questions are discussed in the paragraphs below.

LEADERSHIP OF THE MDCT

Much of the evidence to the Royal Commission was concerned with whether or not a doctor should continue to be the leader of the MDCT as of right and in virtually all circumstances. On the whole the medical organisations argued that he should: thus, the General Medical Council (GMC) commented 'It is also important that the doctor should retain ultimate responsibility for the mangement of his patients since only the doctor has received the necessary training to undertake this responsibility'. In their view this applied both to hospital and general practice. Unsurprisingly, the British Medical Association (BMA) supported this view though recognising 'the necessity of cooperation' with other professions. On the other hand, the representatives of the other professions stress the need for a multi-disciplinary approach, the implication being that nurses, social workers etc. should be at least on a level with the doctor when decisions are being made that affect their disciplines. It is not difficult to detect on the one hand an anxiety on the part of the medical organisations that the doctor's pre-eminence

and authority is being undermined, and on the other, a thrust for status and influence from professions who have in the past been simply the handmaidens of the medical profession.

There is also the question of clinical responsibility. The doctor's lengthier and broader training, and his higher pay and status, made him prominent amongst the caring professions at a time when they were still at an early stage of development. Not only did the consultant or GP have the last word about purely medical matters but his 'clinical responsibility' was extended to all matters affecting his patients. This may no longer be a sensible basis for the relationship between doctors and other members of the team, some members of which can claim to know more about particular aspects of patient care than the doctor. That does not alter the doctor's position as expert on purely medical matters but it does narrow his traditional range of responsibility somewhat. It also modifies his traditional leadership role.

With the exception of a few cases where a doctor's responsibility for a patient is legally defined (for example in the Mental Health Act 1959), it may not be essential that a doctor should be the leader of the MDCT in the sense of having the last word about what is done for the patient. The doctor's role in patient care is in diagnosing and prescribing medical treatment. The nurse in her turn is responsible for nursing care, the assessment of nursing needs and the prescription of nursing care. In a nursing home, the nurse may be the natural leader calling in the doctors and other experts from time to time. In the case of a patient receiving care or treatment in the community, the social worker or health visitor may be the natural leader of the team. The leadership of a team dealing with any particular patient may vary with the situation in which care is taking place. What seems to be required is sensible cooperation and recognition of the expertise (and the boundaries of expertise) of colleagues. At the same time, all members of the team should be clear as to who is responsible for making decisions at any time so that these may be authoritative and implemented quickly. If one person is not recognised as leader there may be a danger that the activities of the various professionals will not be properly

coordinated.

CORPORATE RESPONSIBILITY

There seems to be concern detectable in the evidence to the Royal Commission that the establishment of the MDCT will lead to inefficiency, or as the Fellowship for Freedom in Medicine commented in their evidence to the Royal Commission, referring to the report of the Committee of Inquiry into St Augustine's Hospital 'the proposals of the report would be an entirely new departure whereby members of the team with little or no training in pharmacology and therapeutics could overrule the decision of the doctor'.

These worries seem to be based on a misconception about the corporate responsibility of a MDCT. MDCT working does not necessarily imply that the team has power of veto over its individual members. Each professional in the MDCT has his own area of competence and there is unlikely to be difficulty in the team recognising where this lies. Within his area, the individual member is responsible for his own actions. There may, in addition, be areas where the decisions of an individual professional have a bearing on care carried out by the rest of the team and, in this case, it will be important for agreement to be reached. An example of this might be behavioural therapy which requires the cooperation of all those involved with the patient. However, responsibility of the team should not override the personal responsibility of any member within his own area of expertise.

Given the individual's responsibility for activities within his own professional competence, there need not be any conflict between MDCT working and responsibility to the professional hierarchy. The nurse in a MDCT, for example, is answerable to the nursing hierarchy for nursing standards and this is not altered by the fact that she may be a member of a team making corporate decisions on patient care.

12

CONFIDENTIALITY AND COMMUNICATION

The more people who are involved in an individual's care or treatment the more must have access to his case notes etc. This is inevitable, and perhaps leads to some increase in the risk of a breach in the traditional confidentiality between patient and doctor. However, this kind of consideration does not seem to outweigh the advantages of enabling members of the team to make a proper contribution to the care of a patient. If therefore every professional member of the team is given equal access to the patient's case notes, in return, equally high standards in the maintenance of confidentiality must be expected of all those concerned.

Another apparent difficulty in a team approach is uncertainty on the part of the patient and his relatives as to who is responsible for his case. In practice this may be less of a difficulty than it seems; if a patient has had a serious operation his relatives will want to approach the surgeon and he will be the member of the team best able to give information. In other circumstances another team member may be best able to help. In other words the answer to 'where do I go for information?' is 'it depends what information you want'. It is important not to think only of acute illness or serious injury when considering the general problems. In the end, the MDCT approach may mean that the patient or his relative receives fuller information from those he approaches as all members of the team are aware of the total picture.

LEGAL ASPECTS

The view a Court might take of an action for damages, for example, will reflect and not determine the arrangements made for the care and treatment of the patient. So far case law has probably reflected the pre-eminent position of doctors amongst the health professions and it has been more usual to hold them responsible for damage to patients than members of the other health professions. Where, for example, a nurse or technician appears to be responsible, it is normal practice for the health authority to be sued. In law, however, each professional is responsible

for actions or omissions within his own sphere of competence and there is no difference in the legal status of responsibility of, for example, a nurse or psychologist from that of a doctor. Doctors have long had to carry insurance: it is a condition of a hospital doctor's employment in the hospital service that he should be so insured. The position with nurses appears to be changing slowly and some health authorities now require nurses employed by them to be insured.

About two-thirds of all nurses, mainly those belonging to a nursing organisation, association or trade union, are insured. A court can be expected to apportion blame where responsibility lies, and if there is some shift in responsibility carried by members of a MDCT, a court aware is likely to reflect this. In practice, a health authority will often contest a claim for damages on behalf of its employee, even if it is not sued in its own right.

THE PRIMARY HEALTH CARE TEAM

History of the Development of the Primary Health Care Team

It is perhaps difficult to appreciate the extent to which the context of general practice has changed in the last forty years. Professor Margot Jefferys recently caricatured the pre-war GP as a paternal figure living in relative elegance and professional isolation with the majority of his patients fee paying but an element of them on the 'panel' entitled to consult him by virtue of their compulsory National Health Insurance payment. They entered his premises 'by a side door where they waited in a long corridor for his services'. A book-keeper was more likely to be employed than a nurse. 'Messages were taken by one or other of the maids who grace the establishment'. 'In more solidly working class areas the doctor was still likely to be a single-handed practitioner, but he was more likely, for the sake of his wife and children, to have moved his residence to a more salubrious part of the town while keeping his practice going in a shop close to his potential panel patients.' [1] There has been a substantial shift from this pattern of

general practice to one where numbers of doctors work together, either in their own group premises or in health centre premises provided by the NHS, but they also work increasingly with other health professionals. The concept of the primary health-care team can perhaps be traced back to the *Dawson Report* of 1920 which argued for primary care being provided from health centres[2]. The changing pattern of disease in the community and the explosion of medical knowledge post-war, the formation of the NHS in 1948 and the Royal College of General Practitioners in 1952 were all factors which encouraged doctors to take a broader view of general practice. The disadvantages of isolation were increasingly realised. As doctors grouped together they attracted to themselves other health workers. This coincided with the realisation that special premises were required with adequate space from which to work. Delegation then became necessary and the nurse, health visitor, midwife, medical secretary/receptionist, social worker as well as the GP began to work together.

It is this combination which is the primary health-care team. There is no simple definition of a primary health-care team as it can mean different things in different places, but it clearly involves a situation where more than one GP works together and where a number of health professionals are working in cooperation. The team does not need to operate from the same building or meet every day, although that often happens, particularly in health centres. The concept was founded on the working of different professions together to deliver primary health care services; it is for this reason that the primary health care team is, in the real sense, an example of the multi-disciplinary concept of working. In its evidence to the Royal Commission, the Royal College of General Practitioners commented that 'Primary health care should be provided normally by functionally integrated teams of general practitioners, nurses, health visitors and where appropriate, social workers, supported by receptionists and secretarial staff. Within the primary health care team ultimate responsibility must rest with general practitioners. The Court Report on Child Health Services argued that it provides the most effective vehicle for providing primary health care services in the future.

If one accepts that the primary health care team is the best way of delivering general medical services there are a number of problems which flow from it. The main issues about the team seem to be the same as those for the MDCT in a hospital setting.

(a) Leadership. Implicit in the concept is a common pattern of working with the needs of the same patient being assessed by a team of professionals each with their own skills and contribution. But who is to take the lead? Traditionally the GP has done this but the medical bodies see the GP, at the least, as 'primus inter pares'. But in some situations it may make more sense for another professional to take the lead. How can this be resolved?

(b) Members of the team have both a corporate responsibility to the team and their own individual responsibility as professionals. In addition, as has been pointed out earlier, many of them have different employers. This again can lead to conflict.

(c) Confidentiality. If a team approach is to be adopted, it is clearly necessary that each member has access to common information. In the case of individual patients this inevitably means that more people have access to the information. Thus the risk of breaches of confidentiality is increased.

(d) Legal Responsibility. It seems that the Courts have recognised the traditional major responsibility of doctors and this is why doctors insure themselves against claims for damages as a matter of course. Rarely have other professions been treated by the Courts in quite the same way. But this situation appears slowly to be changing. This may be an issue which needs clarification.

The main differences between the MDCT approach in the community and that in the hospital are firstly, the fact that some members of the team may be employed by the doctor and others by the health authority, and secondly, the problem of bringing in other practitioners such as pharmacists, dentists, chiropodists etc.

CONCLUSION

In sum, it seems that the difficulties seen in a multi-disciplinary approach are more attributable to inter-professional jealousies than to anything more solid. It would be counter productive to lay down hard and fast rules, the advantages of a flexible and sensible attitude to working together in the care and treatment of patients should be noted.

REFERENCES

1 MARSH, G *and* KAIM-CAUDLE, P *Team Care in General Practice.* London. Croom Helm 1976 [Foreward by Margot Jefferys p 7]

2 *Interim Report of the Consultative Council on Future Provision of Medical and Allied Services* [Dawson Report] London, HM Stationery Office, 1920.

APPENDIX A

DEPARTMENTAL DOCUMENTS WHICH REFER TO MULTI-DISCIPLINARY CLINICAL TEAMS

1 *Better Services for the Mentally Handicapped.* London HM Stationery Office 1971, paras 131–138 and 141. *Cmnd 4683.*

2 *The Education of Mentally Handicapped Children and Young People in Hospital.* HSC (IS) 37 paras 8 – 10.

3 *Operation and Development of Services – Child Health Services.* HRC (74) para 37.

4 *Services for Mental Illness Related to Old Age* HM (72) 7l.

5 *Hospital Services for the Mentally Ill.* HM (71) 97 paras 9–12.

6 *Better Services for the Mentally Ill.* London H M Stationery Office 1975 paras 3.5, 3.6. *Cmnd 6233.*

7 *Child Guidance and Child Psychiatry* HSC (IS) 9.

8 *Court Report on Child Health Services* HC (78) 5 paras 12–14.

9 *Hospital Services for Children* HM (71) 22 para 4c.

10 *Priorities for Health and Personal Social Services in England,* London H M Stationery Office 1976. Section III.

11 *Report of the Working Group on Organisation and Management Problems in Mental Illness Hospitals,* DHSS, 1980.

12 *Nursing in Primary Health Care.* CNO (77) 8.

13 *Strategy for Development of Health and Personal Social Services in Northern Ireland.* Belfast H M Stationery Office 1976.

14 *Nurses in an Integrated Health Service* (Chairman Dame Muriel Powell) Edinburgh. H M Stationery Office 1972.

15 *Improving Geriatric Care in Hospital* HC (76) 32.

16 *Doctors and Old Age.* British Geriatrics Society 1976.

LITERATURE SEARCH ON MULTI-DISCLIPINARY CLINICAL TEAMS

Specific literature on multi-disciplinary clinical teams is limited in quality and quantity. Our search revealed only four British references. The concept of multi-disciplinary clinical teams is not defined in these articles nor in any one of the thirty or so foreign articles scanned. Most of the literature concentrates on the psychiatric and geriatric fields, where the approach in the UK is already well known, if badly defined.

A short annotated bibliography of the more useful articles appears below.

British Sources

1 'Teamwork on the wards', *King Edward's Hospital Fund for London 1975:* report of meeting at Kings Fund Centre. This deals with an experiment at West Middlesex Hospital attempting to introduce improved intra-professional communication through 'weekly after rounds meetings', and unstructured floor meetings (including patients). The experiment was monitored by Brunel University. The paper points out that MDCTs are already, and have long been, in existence in most psychiatric hospitals. Problems highlighted are: opposition from middle management leading to reticence amongst most junior staff; and obstructing communication across professional boundaries. A problem exacerbated by the fact that MDCT activity was not always coupled with multi-disciplinary management.

2 'A continued training institute at the New University Hospital of Wales' by KM Lloyd, *Physiotherapy* February 1971: a description of an attempt to introduce co-ordination of training for all health professionals, recommended as early as 1951 in the Cope Committee Report..

3 'A multi-disciplinary approach to psychiatric nursing', by A Atschul, *Nursing Times* April 19 1973: a description of the role of the nurses in the renamed Singleton Hospital where the therapeutic community ideal, decision-making consensus, the 'open-door' policy, and 'crisis intervention' in the community provide a base for multi-disciplinary clinical activity. The writer does not clearly outline a definition of MDCTs, nor does she draw any hard conclusions about the merits of multi-disciplinary activity as compared with any other approach.

4 'Doctors in management II: clinical division and clinical management', *Health and Social Services Journal* 1 December 1973: describes multi-disciplinary working groups at the clinical level in the United Manchester Hospitals. Such groups function in the coronary care unit, the respiratory intensive care unit, and acute renal dialysis. Again, not specific about advantages as compared with other methods, nor any clarity of definition.

American Sources

1 'The team approach in a psychogeriatric unit' by S Goldstein et al, *Journal of the American Geriatric Society* 1975 Vol 23 pt 8 p 370: a study of the staff's attitudes to a 6 month old multi-disciplinary based psychogeriatric unit, concluding that the team approach works; the team can deliver primary care in an efficient manner. This allows the physician's unique capabilities to be better utilised . . .'

2 'Verbal communication between students in multi-disciplinary teams' by M Patterson & S O Hayes, *Medical Education* 1977 Vol II pt 3 p 205: an attempt to be specific. An experiment studying 94 undergraduate students of all health professions

Other Sources

1 'The health care team' by C Wilson sub-titled 'The impossible

dream?' *Canadian Hospital* March 1973: a brief rejection of the habitual and glib use of the term 'health care team'.

2 'Multi-disciplinary health teams' by M Burr, *The Medical Journal* of Australia 29 November 1975: very brief resume of the difficulties.

THE MULTI-DISCIPLINARY CLINICAL TEAM – A WORKING PAPER

Ivor Batchelor

HISTORY AND DEFINITION

The multi-disciplinary team is an aspect of specialisation in medicine. The advance of science has widened our knowledge of aetiology and provided new tools of investigation and treatment. New categories of staff have arisen to exploit these advances, and have themselves contributed to them. Increasingly research, diagnosis, care and treatment have become multi-disciplinary. With this specialisation and increasing complexity of resources available for the delivery of health care have come also problems of coordination, and attempts to counteract the evident risks of fragmentation.

Interest in the psychology of groups and research into their dynamics during and after World War II have had a considerable influence on the development of psychiatry in this country. The concept of a 'therapeutic community' has been widely applied in psychiatric hospitals and clinics, and has had a major impact in liberalising regimes of care and in drawing upon the understanding and therapeutic potential of those who are not doctors. Where this approach to patient care has been taken all those who impinge on the daily life of the patient, whether or not traditionally they have been considered to be therapists and whether or not they are professionals or high up in staffing hierarchies, may be drawn actively into a cooperative effort in treatment. More recently the term multi-disciplinary team has been frequently applied to those engaged in such clinical activities, in the setting of a growth of professional self-consciousness and also with some restriction of membership implied in the change from community to team. Family members, other patients, ancillary staff belonged to the therapeutic community, but could not easily be incorporated into the concept of a multi-disciplinary team.

In hospital and clinic psychiatric settings doctors, nurses, psychologists, occupational therapists and social workers have been the professionals involved. Voluntary workers, though the importance of their contribution is widely acknowledged, have organisationally usually been peripheral to the multi-disciplinary team. Similar developments have occurred in primary care, in the community.

It must be emphasized that, though a multi-disciplinary approach to patient care and treatment is now the norm in psychiatric practice, a formal structured team is much less commonly found; and there is much debate about the nature and implications of teams.

Outside the adult and child psychiatric services similar, self-conscious developments have been much less frequent. Surgical teams have of course long been established, their focus the operating theatre, their aims limited and their leadership unquestioned. In surgical and medical wards those working together have often called themselves 'firms', and their effectiveness has depended much on their group cohesion and morale. The geriatric services have developed in many ways like the psychiatric services; partly because their patients are often long-stay, partly because of the obviously vital contribution of the nursing services to patient care, and partly too because both psychiatrists and geriatricians have been fully aware of the social component in their patients' illnesses. Paediatricians seem to be following a similar pattern of development in their clinical work. Physicians, obstetricians, gynaecologists and others have been slower in appreciating the psycho-social components of contemporary ill health; but here too there is an increasing appreciation of the contribution which can be made by social workers and psychologists, as well as by members of the professions 'supplementary to medicine' who have been used to working closely with doctors and nurses on the wards. Amongst these non-psychiatric categories, it would be rare however for any doctor who was not a geriatrician to consider himself a member of a multi-disciplinary team in any formal sense.

In fact, amongst those who are not psychiatrists, geriatricians or

paediatricians there has recently been some alarm at the increasing references by the health departments and by professions other than the medical, to multi-disciplinary teams. It has been felt by many of these doctors that there is a deliberate challenge to medical leadership and a serious threat to clinical freedom and professional autonomy. This sense of threat has been intensified by the creation, under the recent administrative reorganisation, of multi-disciplinary managerial teams who operate by consensus. A spectre, at least, of diagnosis and treatment by committee has been glimpsed.

It can easily be established that those who use the term multi-disciplinary team employ it with many different meanings and often vaguely. Different and various motivations are also obvious amongst both the proponents and the opponents of such developments. There are at the very least four strands of thought, not always separate or articulated —

(a) that the term multi-disciplinary team is a new fangled way of describing the traditional cooperative activities of health professionals in their daily work;

(b) that it is a new, more structured way of cooperative working which is now the best way of delivering services;

(c) that formal acceptance into membership of a multi-disciplinary team is an acknowledgement of professional status and a step towards professional equality with doctors; and

(d) that membership of a multi-disciplinary team is professionally restrictive to newer and emergent professionals and an acknowledgement of medical dominance; it should therefore be avoided.

MORE FORMAL MULTI-DISCIPLINARY GROUPINGS

The formation of a multi-disciplinary team develops usually out of the

collaboration of members from three or more health-service disciplines; as their collaboration prospers they are apt to come to see themselves and to speak of themselves as members of a team, and to develop that attitude of ready cooperation which is called a team spirit. There are no rules and very few conventions governing the behaviour of such a team. They will meet regularly, to discuss investigations, care and management, progress and problems in the cases of individual patients, and their own professional contributions; and they will from time to time discuss unit policies for admissions and discharges, ward routines and so forth. A doctor usually leads such a team, the largest single category of staff is nurses, and the focus of the team's activities — the patient, is outside the team.

Even in areas of health care such as psychiatry where a multi-disciplinary team approach has long been common, by no means every health professional wishes to work in such a team, even if it is loosely structured. Many are individualists, and some are prickly individualists. Thrust into a team, they would be unhappy and less effective. Teams therefore have to be self-selecting and of mainly spontaneous growth, and their cohesion cannot be forced. Whether the structure of the team is loose knit or close, personal relationships are all important. Many of those who undertake to work in teams feel later a need for some preparation for this mode of working and for a greater understanding of group dynamics.

No one would wish deliberately to interfere with the close collaboration of professional colleagues in the delivery of individual health care, or with the development of teams by professional colleagues if this is the way in which they wish, and can best, work. But there are administrative structures which could render this collaboration more difficult: these are the administrative hierarchies in nursing and social work which may influence the nurse and social worker in the clinical situation in a way which is foreign to the doctor. It is important that this influence should not be unhelpfully constraining, by delimiting roles or functions too conventionally or rigidly.

LEADERSHIP AND RESPONSIBILITY IN THE MULTI-DISCIPLINARY TEAM *

The patient, his relatives, the administration must know who is ultimately responsible for this patient's welfare. A team certainly develops a sense of corporate responsibility, as it will have a feeling of belonging together and of sharing intimately in the work: but this sense of corporate responsibility is ethical, not clinical or legal or administrative; and a clinical team has no power of veto over the actions of its individual members. On the other hand, clinical responsibility cannot entirely be fragmented. Leadership is necessary, and such leadership cannot be subject to rapid change. Without leadership, the disruptive effects of increasing specialisation, a divergence of policies and concerns, would be very difficult to contain.

In management teams decision making may be a lengthy process, subject to long discussion, wide consultations, negotiation, delay or indefinite postponement. In the clinical situation the needs of the individual patient are clamant, decisions have to be made expeditiously, investigations and consultation have a short time-scale. The clinical team must therefore have a leader who brings all relevant resources to bear quickly on the patient's problems, who has the authority to get things done and who makes the final decision if there is doubt or even disagreement, in the team. This team-leader must carry overall responsibility, not for the individual contributions of the other professionals who contribute to the patient's care, but for the proper clinical investigation and treatment of that patient.

Usually therefore, both in hospitals and in the community, the doctor is the natural leader of the multi-disciplinary team. Such, we believe, is the public's expectation: such is the reality of the present

* Parts of this section were used by the author in a Sandoz Foundation Lecture at the University of Edinburgh, May 1980.

arrangements for care and treatment in the NHS. It is not necessary to defend this situation by referring to tradition or convention, to the requirements of the General Medical Council (GMC), to the wishes of doctors or to legal constraints. The critical authority which the doctor carries is that of expertise. In the great majority of clinical situations the dominant expertise is that of the medical consultant or general practitioner, since he has had the most comprehensive training and the widest experience. His resource in diagnosis is unchallenged by any other health professional, his is the most extensive knowledge of the available treatments, and he alone can mobilise all the resources of the service.

A leadership which derives from expertise has no need to be authoritarian. It should be part of that expertise to enlist in the most constructive way the contribution of all those other health professionals who can assist in an individual patient's care; and to assure them, so far as it is practicable, the best conditions for their work. They should be given as large a responsibility as possible to deliver their individual professional expertise according to their own judgement. The leadership role will usually be that of initiating, and of coordinating, the work of the other team members. The more secure and respected the doctor's leadership, the less will be the need to insist upon it. The team will function then as an easy grouping of colleagues, fortified by feelings of mutual respect and not concerned with individual shifts of status.

Coordination is not the responsibility of the team leader alone. All those working in a team have an obligation to coordinate their work with that of others; and both in hospital and in the community nurses play a vital and irreplaceable role in coordinating the detailed work of day-to-day patient care and in providing for its continuity.

Probably the medical profession has been less sensitive than it should have been, and might have been, to the problems of leadership in a democratic society. Sometimes it has seemed to take its position too much for granted, and to insist upon it as one of unarguable and unchallengeable right. There have been defects too in medical education,

in that the doctor who has now to work so closely with other health professionals has neither had the contact he should have had with them during his training nor adequate instruction in the nature of the contribution which they can make to patient care and treatment.

LEADERSHIP AND THE ROLE OF OTHER HEALTH PROFESSIONALS*

The doctor's leadership role has been modified by the emergence under his aegis of other health professions, and by their assumption of responsibility for activities within their own professional competence. Members of the team other than the doctor can now claim, on substantial grounds, that they know more about particular aspects of patient care than the doctor. He continues to have an overall clinical responsibility for the care of individual patients; but the nurse is now responsible for the assessment of nursing needs and for the prescription and delivery of nursing care, and other professionals in the clinical field have similar responsibilities in their particular disciplines. Should then the leadership of the team change according to the nature of the service which is being given, and the setting in which this is occurring?

There are only two professional disciplines which can and have challenged the doctor's traditional role in clinical responsibility: these are nursing and clinical psychology, and their positions will be briefly reviewed.

Doctors and nurses have traditionally worked very closely together and usually in harmony. Recently the relationships between the two professions have at times been strained. No doubt many factors have contributed to this – the changing status of women in contemporary society, the higher status of nursing in the NHS as evidenced by salary levels, the enhanced quality of the entry into nurse training and the

* Parts of this section were used by the author in a Sandoz Foundation Lecture at the University of Edinburgh, May 1980.

improvement of that training, the 'Womens' Liberation Movement', the too cosy paternalism or autocratic bossiness of some doctors, the 'Salmon' structure, the increased number of men in senior positions in the nursing hierarchy, the operations of trade unions in nursing – no doubt there have been other factors and these have not been listed in any order of supposed importance: such a listing is however sufficient to indicate that the situation has been complexly determined. Nurses have become much more conscious of the specific nature of their professional contribution and more assertive about their status among the health professionals. They no longer and rightly so, wish to act as 'handmaidens' to doctors. They are questioning their role in multi-disciplinary teams. They wonder whether they themselves should not sometimes (or often) be leading such teams; at least in the long-stay sectors of the NHS where care is a far larger component than medical treatment of the service which patients receive.

It may be that the NHS will encourage and itself make provision for nursing home care; and such a nursing home might well be in the clinical charge of a nurse (Matron). In the event of a change in the patient's illness or disability or a further episode of illness the nurse would, on her own judgement of the situation, decide whether or not to call in a doctor. She might have as elements in the team supporting her not only nurses but physiotherapists, occupational therapists, social workers. Such a nursing home form of care might be developed not only in the community but also in the long stay areas of psychiatric and geriatric units or hospitals. No doubt there will be much experimentation with forms of care which are alternatives to what has been traditional; and in these circumstances both the constitution and the leadership of clinical teams would have to be reconsidered. Here nurses would have excellent opportunities to expand their roles in care and to accept an increasing degree of responsibility.

Though the nursing services give 24-hour continuity of care in hospitals, and extensive care in the community, individual nurses do not give as great a continuity of service as consultants and general practitioners;

their professional lives are usually much shorter. They have not had the same experience as doctors in carrying responsibility, and no doubt there would be many who would not wish to carry a heavy clinical responsibility. In claims for the leadership of clinical teams, the nursing profession would have to take these factors into account.

Clinical psychologists in the NHS now wish to be seen as having full and independent professional status, and are doubtful about (though at present they accept) the continuing medical responsibility assumed by doctors. They are detaching themselves to some extent from the psychiatric services in which their discipline developed, to form area services dealing directly with general practitioners, paediatricians, neurologists, geriatricians and other specialists. In such situations their expertise is more novel and they operate more as independent consultants than they used to do within the psychiatric services. They are well aware of the delicacy of the area of relationships and clinical responsibilities into which they have entered. In the report on 'The Role of Psychologists in the Health Services' (Trethowan Report) 1977, it is recommended that 'relations between psychologists and the members of other health service professions should be based on multi-disciplinary teamwork'. But the report's approach to such teamwork seems somewhat guarded and ambivalent. It interprets the concept of multi-disciplinary teamwork as implying a shared responsibility for patient care and refers to 'decisions which involve the team as a whole': it adds, 'this does not, we must emphasize, mean that every decision affecting a patient will necessarily be a team decision'. Consensus clinical management is therefore to some extent suggested but not definitely advocated; while the question of team leadership is avoided and put in doubt. The full clinical responsibility . . . of certain medical practitioners is acknowledged but psychological techniques and procedures are not considered to be 'medical forms of intervention'. Many psychiatrists at least think that they are.

The importance of the contribution which psychologists are making, and increasingly can make, in many clinical areas of the NHS is undoubted: so is their growing professionalism. Having been granted

their professional identity and independence we hope that clinical psychologists will not assert it unduly. If clinical psychologists continue to work closely with clinicians and nurses, all three disciplines will benefit and so, we believe, will their patients. If however psychologists in the NHS were to try soon to gain a position as independent practitioners in certain areas of psychological medicine they could damage both their present position and their status. Their professional status is not yet widely or fully established, their training and clinical experience are still limited in range, and they do not yet have a sufficient armoury of effective techniques to justify such a leap ahead. We understand and sympathise with their impatience to apply their knowledge and skills to all those who might be helped by them: but at this stage in their professional development we believe that their future will be better assured by broadening and deepening their research and so giving their practice (and the practice of many of their clinical colleagues) a more secure foundation, than by attempts to extend their clinical responsibility in manifest competition with doctors.

CONFIDENTIALITY AND COMMUNICATIONS

The more people who are involved in an individual's care or treatment the more that must have access to personal information about him. This is inevitable, and must lead to some impairment of the traditional confidentiality between patient and doctor. The most intimate personal details may of course be given in confidence, and this confidence will be respected by any health service professional: but an extensive bar by a patient to discussion amongst professional colleagues of facts relevant to the understanding of his illness could be prejudicial to that patient's care. The advantages of enabling members of a team to make their full contribution to the care of a patient are great. We therefore take the view that every professional member of a team should have the clinical information upon which comprehensive care and treatment can best be based. In return, equally high standards in the maintenance of confidentiality must be expected of all those concerned.

LEGAL ASPECTS

We come to these last because it seems to us that the view a court might take of an action for damages, for example, would reflect and not determine the arrangements made for the care and treatment of patients. It appears to matter very little to the law how the members of several professions might organise themselves to work together, or how they might view their responsibility to and for each other. Each health professional in the NHS is responsible for his own failure to exercise reasonable professional skill and care, but not for anyone else's failures. Although the doctor may set the physiotherapist, for example, in motion, he neither employs her nor acts jointly with her. He simply asks for cooperation from a para-medical profession. Each should be aware of the other's activity to the extent necessary to carry on his own; and it will be part of his or her reasonable professional skill to inform himself or herself properly . Most medical negligence claims arising out of treatment under the NHS are directed against the employing authority.

CONCLUSION

What is required in the clinical situation is a flexible and sensible attitude to working together, and mutual respect for one-another's skills and opinions. Doors should be left open to development rather than rules for change prescribed. We think that the evolution of multi-disciplinary teams should be left now to local initiative and experiment. The central health departments have given sufficient indication of how the various disciplines of health professionals can and perhaps should work together. More attention should be paid in the education of all health service professional staff to their preparation for well-informed and easy cooperation after qualification. It is only in the psychiatric field that a sophisticated education in group dynamics may in some instances be required, though an introduction to this subject should be included in the undergraduate teaching of behavioural sciences. We trust that leadership in the delivery of patient care will not continue to be a contentious issue.

Any change in this respect should depend upon established developments in the methods of delivery of health care – upon developments, that is, determined by the needs of patients, not by professional ambitions; and any considerable alterations in role must be preceded by alterations in the education for that role.

THE MULTI-DISCIPLINARY TEAM

Jean McFarlane

PHILOSOPHY AND OBJECTIVES

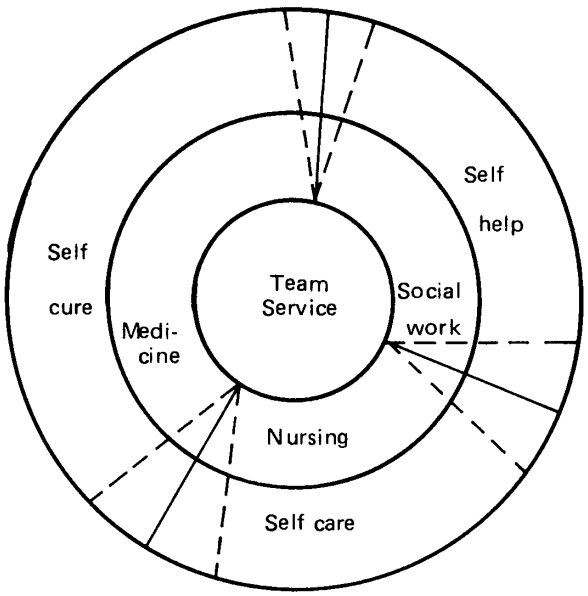
Much of the confusion surrounding the discussion of multi-disciplinary teams may arise from terminology. Traditionally there has been a propensity to label all health care as medical care, and the distinct and unique contribution of doctors has not been identified. Because one now needs to be able to distinguish adjectivally the care which doctors give from the care given by other health professionals, I believe it is less confusing to talk of health care as that which embraces the function of all health workers and medical care as that given by doctors, rather than to talk of 'the greater medical profession'.

Much of the evidence to the Royal Commission on the NHS stressed the doctors' responsibility for clinical care or treatment. I believe it is necessary to distinguish between clinical medical care and medical treatment, and the clinical care and treatment given by other professions.

One of the criticisms of the health service in the past has been its narrow disease orientation. I believe this to be the result of an undue emphasis on the medical function, namely diagnosis, treatment and cure of disease, whereas the health needs of individuals and communities are far wider than this and embrace a range of professional and non-professional functions which the medical profession can only partially fulfil.

In the meeting of health care needs 'there is an extremely complex interaction of a team of professionals with the patient, his family and the community. It is likely that in team function, there will be an overlap in roles but it is also important to distinguish the unique input of each member of the team[1]. This is well illustrated by the diagram of

relationships given by Hall (Copenhagen).



The primary objective of any team function, therefore, is to coordinate the health care given by different contributors to an individual which might otherwise remain uncoordinated or even in conflict. In this respect I suggest that since the team directs its efforts to the care of an individual and the needs of the individual:

(a) the team may have a different membership in each case even though there may be a relatively stable core of people working together;

(b) the patient and his family are always members of the team. Health care is not something which can be 'done to' the patient without his active acquiescence and ideally his cooperation. Professions such as nursing and social work which make a major contribution to health care recognise that their contribution is primarily to help or assist the patients and their families to do the things they normally do for themselves. The patient, therefore, in almost all nursing and social work situations needs to be consulted and actively involved in the plan of care and is as much a member of the team as the professional;

(c) different members of the team make a contribution of varying importance in the various health settings. Henderson (1966)[2] illustrates a variety of situations in which the contribution of members of a team (physician, social worker, clergyman, nurse, the patient and family) are represented by wedges of a circle. In some of these the nurse has a large wedge illustrating her major role, for example in caring for an elderly disoriented man in a nursing home; in others she plays a minor role, for example with a rational adolescent girl under treatment for acne in a doctor's surgery. In the text Henderson suggests that '. . . . in some situations certain members of the team have no part of the pie, and the wedge must differ in size for each member according to the problem facing the patient, his ability to help himself and whoever is available to help him'.

The objective of coordination is achieved by communications, planning and monitoring. The team may use different strategies (meetings, written plans, ward rounds, etc) and much may depend on the health situation as to who may be involved. I suggest that the team function is very different in a one to one consultation with a GP, in a therapeutic community, in a geriatric ward and an acute surgical ward.

LEADERSHIP OF THE TEAM

The leadership of the clinical team is also complex. In the first place,

multi-disciplinary health care brings into juxtaposition a number of different hierarchically arranged teams. The consultant is head of the medical team and the ward sister of the clinical nursing team. Both teams operate within NHS and hospital policies. The day-to-day clinical care of patients may well be carried out by more junior members of the team. A great deal of medical decision making is carried out by registrars without reference to the consultant. Similarly Lelean (1974) has shown that the ward sister is often unaware of the nursing care actually carried out which may deviate considerably from that which was prescribed by her[3]. It could therefore be hypothesised that the meeting of the leaders of the two major clinical teams (consultant and ward sister) can be relatively ineffectual in ensuring that agreed objectives are carried out.

The situation may be worse than this. In some situations the only ward round carried out by a consultant each week is a teaching round for medical students which up to 30 may attend. There is no consultation with the ward sister about a coordinated plan of medical and nursing care and the patient is rarely addressed. This kind of 'team work' should be balanced against other situations where it works very creditably. I suggest that in many acute cases the real clinical team is composed of the staff nurse or senior student nurse with responsibility for making the individualised nursing care plan and the registrar taking the major medical responsibility. The operational team may be different in chronic or long-term or psychiatric cases.

If the major objective of a clinical team is to coordinate the plans of care evolved by different health workers, then it would seem logical that the member of the team taking major responsibility for the care of the individual should be in the leadership position. This does not mean that the leadership of the team may change from moment to moment. It is even possible to define broad categories of problems which would designate a certain professional as the team leader. In this respect Henderson's analysis of those who have the major role at any time by (a) the problem, (b) the patient's ability in self help, and (c) the help available, is useful.

On the face of it there are many situations in which the major problem is a medical (disease) problem. In a case requiring surgical intervention the major role may be that of the surgeon. The problems in self care arise out of the action of the surgeon and the nursing function therefore supports that function. But at the other extreme, there are cases of ageing where the primary problem is not medical but a normal loss of function and ability in self care associated with ageing. In such cases the nursing role is the major one and the medical function supports the nursing function, it may be by the prescription of drugs to help in functions such as sleeping, elimination, etc. It could be argued that the nurse could prescribe such drugs on a limited formulary since the patient himself may purchase laxitives etc. at other times in the life cycle.

If the realities of these health situations are analysed it is no longer appropriate that doctors should assume primacy over other professions taking the major responsibility for caring. I suggest that medical leadership of the team often restricts the full assessment of health needs, particularly in cases where the medical model of care is inappropriate to the problem, eg in terminal care.

TRAINING

Primacy over other professions and the concept of an encompassing profession is often claimed on the basis of the superior education of the medical profession vis-a-vis other health professions. It is true that the basic medical curriculum followed by post-graduate training before achieving consultant status is lengthier than that for other professions, but despite some liberalising moves, the medical curriculum is still fairly narrowly directed at disease processes and the treatment of disease. To 'encompass' the work of other health professions in the future would call for a fundamental revision of the medical curriculum and a far greater emphasis on behavioural sciences. It is doubtful if this is a realistic objective if one looks at advances in medical knowledge and the degree of specialisation demanded. In any event 'longer' education should not be equated with 'better'. It is my view

that doctors can no longer lay claim to leadership of the multi-disciplinary team by virtue of 'embracing' knowledge but only by virtue of the problem which the patient presents being predominantly a medical problem.

On the other hand, nursing education has been inadequate in the past for clinical leadership in their own field. In many instances the clinical leadership of nurses has fallen by default to doctors who have directed them into functions which support medical treatment. It is my view that the nursing care of patients has remained an under-developed area. Only recently has research and education enabled some nurses to develop a more scientific approach to assisting individuals in activities of daily living which may or may not be affected by disease and its treatment. I believe that nurses need to be encouraged to develop their own clinical expertise and leadership. If they are to take greater responsibility in geriatric and primary care then their education will need to enhance their skills of assessment and ability to prescribe nursing care. Already degree programmes are producing a very different calibre of nurse well able to make clinical nursing assessments and the revised General Nursing Council Syllabus (1977) emphasises these skills in SRN training. Many of the Joint Board of Clinical Nursing Studies courses have a research content in post-basic education which is giving nurses a knowledge of research which has been conducted in their own field and which should inform their action.

Much of the medical evidence has stressed the need for someone (a doctor) having overall responsbility for a case. In my view each professional is responsible for their own area of function. I as a nurse would not expect or wish to direct the function of a doctor, nor would I expect a doctor to direct the function of a nurse. There is however a need for our respective functions to be coordinated in the care of an individual patient. In the best teams this is done on a basis of mutual respect and discussion. I would expect to take into the plan of nursing care consideration of the medical treatment of the patient. I would expect a doctor to take into consideration the nursing implications of his plan of medical treatment. Both of us might have to modify

our plans. Both of us might have to be informed of aspects of the other's plan. In neither case is there any basis for 'authority' being exercised over the other. The relationship is one of colleagueship. Hence responsibility for medical treatment rests with the medical profession and the control of medical treatment must rest there. Similarly responsibility for nursing care rests with the nursing profession. No form of leadership can detract from this.

SUMMARY

In summary it is my view that there is no unitary concept of the MDCT. But health professionals need to work together in a coordinated way and need to find strategies of coordination. It is virtually impossible to define the membership of the MDCT. It consists of the patient and his family and those health workers best able to help with his problem. Health problems are not just medical problems. Each member of the team is responsible for his own actions and 'leadership' does not confer the right to direct other members of the team. The style of leadership required is that demanded by the coordination of the work of colleagues. It is not the leadership of the coachman with a team of horses and a whip but rather that of the team game, where whoever has the ball leads the action.

A doctor or a nurse may lead the team depending upon the predominant patient problem. Medical education does not equip doctors with an 'embracing' knowledge. Nursing education has been inadequate for the role demanded by the nature of nursing function.

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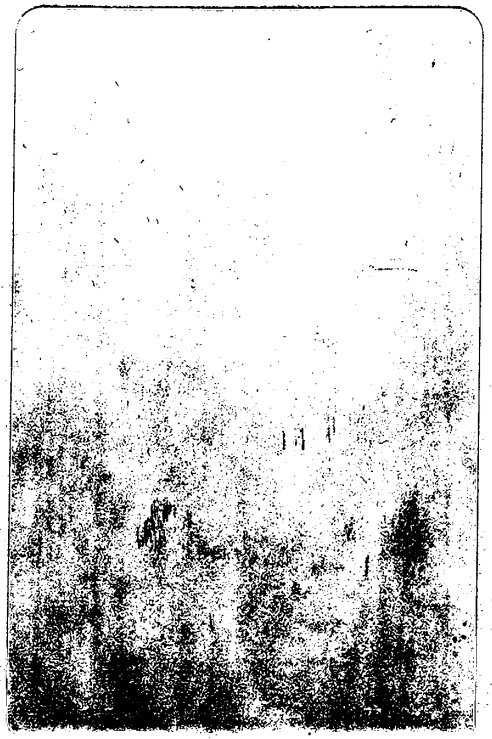

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LIST OF TITLES IN THIS SERIES

Paper No.	
RC1	Conflict and Consensus: An analysis of the evidence submitted to the Royal Commission on the NHS
RC2	Essays on Nursing
RC3	The Expanded Role of the Nurse
RC4	Ideology, Class and the NHS
RC5	Consumers, Community Health Councils and the NHS
RC6	NHS Finance and Resource Management
RC7	Deputising Services, Prescribing in General Practice and Dispensing in the Community
RC8	Health Education and Self Help
RC9	International Comparisons of Health Needs and Services
RC10	Health Service Objectives
RC11	The NHS and Social Services
RC12	Multi-disciplinary Clinical Teams
RC13	Aspects of Dentistry
RC14	The Nation's Health and the NHS
and	Further papers prepared by the Secretariat and Members of the Royal Commission on *Hospitals, Management* and *Manpower* in the National Health Service