Multidisciplinary Teams

A Personal View

By Philip H. Connell

The contributions to the *BMJ* on multidisciplinary teams, the editorial and subsequent correspondence[1,2,3] have raised and ventilated, sometimes with heat and sometimes inaccurately, many different issues and points of view concerning the ways in which different professional persons work (or don't work) together.

All this has evoked in me a sense of *déjà vu*, for in the late 1950s there was considerable comment of the same kind in the field of child psychiatry. The controversy was about who should direct child guidance clinics—some local authority clinics had educational psychologists as Directors, whereas the RMPA issued a document defining the functions of the Medical Director of a child psychiatry/child guidance clinic[4], and our present Child and Adolescent Psychiatry Section has recently brought out a further document on this matter.[5]

In the last twenty years there has been a marked growth of professional groups with spheres of influence and interest and a framework of practice, such as social workers, psychologists, nurses, community physicians and so on. Furthermore, the development of training of a more definitive kind, sponsored by the appropriate professional representative body, has led to improvement of professional standards and increases in professional status. This has certainly contributed to the welfare of the mentally ill, the inadequate, the maladjusted and the disadvantaged in our present society, but it has also added to the complexities of work in these and related fields.

Few professional persons will be happy or satisfied in their work these days unless the work carries status and responsibility. The kind of responsibility typified by the surgeon who, after consultation with colleagues and paramedical persons, decides on what operation is to be performed and when it shall be done, is hardly applicable in areas of psychiatry where members of the professional team may each have independent responsibility for some aspect of the work. The clinical psychologist, for instance, cannot be instructed to carry out a certain test if he considers that the test would be unhelpful.

It must be recognized that in the last twenty years or so there have been many developments within each specialist group. The psychologist of today is less concerned with 'tests' to define mental function of ability and more with treatment for behavioural abnormalities (whether labelled with a formal psychiatric diagnosis or not).[6] Nurses too are much involved with the actual treatment of psychiatric patients than used to be the case—hence the development of nurse therapists with further training and responsibility.

Whatever the training, however, there will be some doctors who are reluctant to make decisions and who need the help of colleagues of other professions to come to a decision, and others who, even if they do consult colleagues, will make their own decision even if it runs counter to the views of these colleagues or the available evidence.

It must also be remembered that in psychiatry, geriatrics and community medicine there is a considerable overlap in the fields of professional practice, so that there has to be some way of intercommunication. Whereas a telephone call may be the most efficient way of dealing with a relatively simple executive matter, on more complex issues a discussion in a multidisciplinary team allows a more comprehensive scrutiny of the issues and enables the members of the team to feel that their contributions are valuable and appreciated, thus assisting in the maintenance of morale.

So far as responsibility is concerned the College has made its views clear. In the memorandum on 'The Responsibilities of Consultants in Psychiatry'[7], after a long and careful analysis of multidisciplinary teams, it is stated that 'The Consultant has a direct responsibility to see that the variety of disciplines caring for patients are co-ordinated and used effectively to pursue the major objective of the best treatment of the individual patient in his medical care. This implies leadership of the multidisciplinary teams dealing with clinical problems and accepting the responsibilities of leadership'.

The situation in a child guidance clinic under the Inner London Educational Authority, in which the doctor is not necessarily the leader, has recently been referred to in the *BMJ*[1]. Discussion with a psychiatrist working in such a clinic led to the remark that although the doctor may not theoretically or officially be the team leader, members soon come to the doctor if they find themselves in difficulty!

Issues of status, power and responsibility are bound to crop up from time to time and cause anxieties. Psychiatry has become increasingly involved in fields which are based less and less upon the hospital bed and individual doctor-patient relationships. Multidisciplinary teams have evolved as a response to attempts to provide better patient care. It is not possible to legislate for responsibility to ensure that the group of persons involved in the care of a patient will work as a team should and will provide better health care. It must surely be significant that so many different bodies and reports have stressed the value of communications through such teams.

It is often said that the natural leader for such a team is the doctor, since he has the longest and widest-ranging training of all the professional groups. This may be true but is perhaps less so now than when the other professional groups were fewer in number and had less comprehensive training. Perhaps the most important aspect of medical training,

which is seldom referred to, is the exposure to the philosophy of caring—the taking responsibility for patients at an early stage of training and personal experience of treating the sick, the dying, those in pain, and so on. This includes responsibility for and continuing care of the patient for whom there is no 'cure'.

The issues raised in the correspondence referred to are particularly relevant to the age we live in, where accountability receives increasing attention in the practice of the Courts. It is reassuring that these matters evoke contributions from such a wide range of individuals and professional groups who speak not only as individuals, but also as representatives of the appropriate professional body. It is hoped that such frank discussion can lead to planned changes rather than *ad hoc* developments and that it may become easier to dismantle new arrangements which have been shown by research and experience to be doing more harm than the ones they have replaced.

References

[1] Appleyard, J. & Maden, J. G. (1979) Multidisciplinary teams. *British Medical Journal, ii,* 1305-7.

[2] Editorial. Who carries the can? (1979) *British Medical Journal, ii,* 1245.

[3] Correspondence. *British Medical Journal* (1979), ii, 1509-11; 1590-1; (1980) **280,** 49-50; 118.

[4] Royal Medico-Psychological Association. The functions of the medical director of a Child Psychiatry (Child Guidance) Clinic. *Journal of Mental Science:* Supplement, November 1961.

[5] Royal College of Psychiatrists. The role, responsibility and work of a consultant child psychiatrist. *Bulletin,* July 1978, p. 127.

[6] Department of Health and Social Security. The Role of the Psychologist in the Health Service (The Trethowan Report). 1977. HMSO.

[7] Royal College of Psychiatrists. The responsibilities of consultants in psychiatry within the National Health Service. *Bulletin,* September 1977, p. 4.

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Obituary

Astor Balfour Sclare

The untimely death of Dr. Astor Sclare, a senior and distinguished psychiatrist, occurred on 17 February 1980. He had collapsed that morning while playing golf, a game which gave him great pleasure as did his other great interest, music.

Astor Balfour Sclare, elder son of the late Dr. Isaac Sclare whose career in psychiatry he was later to emulate, was born into the Jewish community of Glasgow on 14 September 1922. He spent his earlier years and most of his professional life in Pollokshields on the south side of Glasgow where he went to school. He had an outstanding undergraduate career in medicine at the University of Glasgow, gaining several prizes and distinctions, and graduated MB ChB in 1944.

After a resident appointment in medicine at Hairmyres Hospital he spent 2½ years of national service in the medical branch of the RAFVR, where he gained sufficient experience in psychiatry to become a diplomate in psychological medicine. On demobilization in 1947 he worked in the University Department of Medicine, Western Infirmary, with Sir John McNee and assisted Dr. David Yellowlees at the Landsdowne Clinic. During this period he became an FRFPSG and an MRCP of both Edinburgh and London.

Appointments with Professor Ferguson Rodger in the University Department of Psychological Medicine followed. He was awarded a Harkness Fellowship of the Commonwealth Fund and spent session 1950-51 with Professor M. Levine at Cincinnati, USA. Returning to Glasgow, he was appointed lecturer and then senior lecturer with honorary consultant status in the University Department of Psychological Medicine. In 1959 he was appointed Mackintosh lecturer in the University of Glasgow and consultant psychiatrist in charge of the Department of Psychiatry of the Royal Infirmary Group of hospitals. He thus assumed responsibility for the Department of Psychological Medicine in Duke Street Hospital, over which his father had once presided.

He was elected a Fellow of the Royal College of Physicians of Edinburgh in 1959, and of the recently formed Royal College of Psychiatrists in 1971.

Astor Sclare had by the time of his appointment to the Royal Infirmary already demonstrated his ability as clinician, teacher and researcher. He had a substantial list of publications, which continued to increase over the years. He believed that psychiatry was best practised and taught not in isolation but in relationship to medicine as a whole. He transformed his Department, including the establishing of Carswell House where out-patients could attend without embarrassment or sense of stigma. He established happy and fruitful collaborations with colleagues in other branches of medicine as well as in psychiatry, and he exercised to the full his diplomatic skill in persuading psychiatrist colleagues in the Eastern District of the city to establish a division of psychiatry incorporating Gartloch Hospital.

He was a lucid and stimulating teacher, popular with colleagues as well as undergraduate and postgraduate students. He also had a firm grasp and wide experience of administrative matters. Inevitably there was an increasing call on his skill and time, not only by colleagues but also by other professional groups and national associations. Many