# Trainees' Forum

## Conflict and Consensus in the Multi-disciplinary Team

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During my training I have had the relatively unusual experience of two placements in community psychiatry—one at registrar, the other at senior registrar level. These placements were in many respects quite different. One was in an Emergency Psychiatric Service based in a London teaching hospital and the other was in a domiciliary-based Crisis Intervention Service in a district general hospital. A feature shared by both services was a multi-disciplinary team. The move towards community psychiatry is going hand in hand with the multi-disciplinary approach, and this leads inevitably to some re-evaluation of the role of the psychiatrist as other disciplines contribute more to clinical assessment and management.[1] From my own experience as a member of these teams I have noted the relevance of two overlapping issues; these concern attitudes to the practice of psychiatry and the distribution of responsibility within the team.

**Attitudes to the practice of psychiatry**

Presented with the complexity and variety of clinical problems, most psychiatrists recognise that there is no single general theory on which they can base all their work. Biological, dynamic and social factors may interact and the psychiatrist needs to be flexible enough to select the appropriate approach for a particular patient. This recognition has contributed to the development of multi-disciplinary teams.[2] In my experience it is not always possible to assume that there will be that flexibility, or indeed that it will be possible to reach a consensus of opinion between members of a team. There are several areas of conflict which include the siting of assessments, the indications for hospital admission, the individual versus the family as patient and the question of responsibility when a patient is at risk.

In the Crisis Intervention Service in which I worked a tradition had arisen whereby it became mandatory policy to assess the patient at home whenever possible. In some instances patients were sent home from casualty departments to be assessed. It is clearly beneficial to see many patients at home in the first instance but there are also those who will either be at risk in the community pending assessment or would benefit in terms of motivation from actively seeking help in another site. Where the policy has become inflexible this may reflect the idea of the hospital representing a medical model and vindicating a sick role. Non-medical team members may feel that they have greater influence and freedom away from the traditional hospital domain.

One of the advantages of multi-disciplinary teams is that they provide and strengthen links with services in the community. Community psychiatric nurses frequently work in close association with GPs, and social workers based in the community have knowledge of local resources. The combined skills of these professionals make it possible to contain individuals in the community who might otherwise have been hospitalised. This allows a more flexible and considered response than would be possible in a traditional service where a frequently inexperienced junior doctor working in isolation is presented with an emergency and has little alternative but to admit, whether or not this is in the patient's long-term interest. However, it is also possible for a team to be so determined to manage a patient outside hospital that they view admission as a failure. In these instances there can be a split in the team such that the psychiatrist may see admission as the optimal first step in management. The social worker may vehemently oppose this. When this conflict is not anticipated and addressed it can lead to unseemly disputes occurring in the patient's home.

Some psychiatrists, and even more mental health professionals from other disciplines, are increasingly interested in family therapy using a systems theory approach. Here the patient is viewed as the 'symptom carrier' for the disturbed family. While most psychiatrists would be prepared to acknowledge the usefulness of this in some cases, general adult psychiatrists work mainly with individuals and our training emphasises this. My experience in the Crisis Intervention Team was that social workers frequently wanted to carry out the entire assessment with all family members present. Patients on the other hand often wanted to be seen alone for the understandable purpose of attempting to confide things that might otherwise be difficult. Psychiatrists would rarely question the relevance of diagnosis to management but it cannot be assumed that other professionals share that view. I have seen family therapy used unsuccessfully as the sole approach to treatment of a floridly psychotic young man, where the team addressed issues of separation from the family to the exclusion of his individual need for treatment.

Lastly, psychiatrists recognise that with increasing severity a functional illness may become an autonomous process which the individual thus cannot control. An extreme view which I have encountered in some teams is that all psychiatric symptomatology represents a demand for external control. Although this may be true in some cases, it may not be near to consciousness, and containment may need to be provided while insight becomes a possibility. This assumes an acknowledgement of the varied concepts of genetics and the unconscious without which the individual may be seen as at all times totally responsible, which may in turn lead to a punitive attitude to treatment. Such extreme views are unusual. More common is confusion leading to a conflict about the balance between the needs of the patient

and his rights as an individual in an open society. This is a problem that can cause disputes between any social worker and psychiatrist doing a Mental Health Act assessment in the community. The difference in the multi-disciplinary team is that the same psychiatrist and social worker must go on working together and such disagreements must eventually be resolved.

**The distribution of responsibility within the team**

It is useful to consider this in terms of two extremes—on the one hand the situation whereby the consultant psychiatrist considers himself personally totally responsible for every activity of every member of his team and on the other hand the concept of a totally democratic system where decisions are reached by a majority view. When a team is led by an autocratic consultant his readiness to take upon himself all decisions can relieve other members of anxiety. However, the price paid for this can be a stifling of initiative and a loss of a contribution from other disciplines. This would seem to negate the entire virtue of the multi-disciplinary team—that of bringing different perspectives to bear on the case. It also produces very strong resentment on behalf of those who are undervalued.

It is not always the psychiatrist who is dominant to the extent of being autocratic. Another mental health professional, for example a social worker, may come to dominate a team working in the community. If all assessments take place in the community and the consultant psychiatrist can take part only in some, then the social worker will frequently be working with doctors in training grades and may be more senior in his own particular hierarchy as well as more experienced in mental health work. Non-medical mental health professionals frequently occupy posts for longer than doctors. They have greater experience of the particular service and may have had a formative influence in its evolution. Doctors in training grades rotate frequently at relatively short intervals. They may therefore look to other members of the team for guidance, especially if they themselves have little experience of psychiatry. Also by tradition they carry with them the stigmatising epithet 'junior' which may be taken too literally.

In multi-disciplinary teams there will inevitably be some blurring of boundaries regarding the work done by different professionals.[1] Counselling, for example, is a skill possessed by all disciplines and is therefore not the sole preserve of any one of them. Contributions from different perspectives inevitably lead to joint decision-making and some decentralisation of authority. Working in the community, the team may more frequently encounter the sorts of problems for which traditional medical and pharmacological interventions would be unsuitable. All these factors tend to undermine the pre-eminence of any particular discipline thus making for a democratic team structure. When this is taken to extremes certain problems may arise.[3] There may be total confusion about who does what within the team and this may generate feelings of insecurity centred around what happens when things go wrong, where the buck stops and who, if anyone, takes overall responsibility.

Total power sharing is a Utopian ideal that is difficult to effect in reality. Society expects the consultant psychiatrist to have "ultimate responsibility and overall authority to diagnose illness and prescribe treatment" and to be the leader of the team. This is endorsed by the Royal College of Psychiatrists.[4] This implies that when things go wrong the psychiatrist is responsible. Other disciplines do not necessarily agree with this. Furnell et al.[5] point out that the law relating to negligence requires that the psychiatrist is responsible for his own work and for ensuring that if he refers or delegates to another that this is a person appropriately qualified and competent. Having done this he is not responsible for that other person's failures in the way that a military commander might be. Furnell states that there is no consensus and no legal definition as to what is meant by "ultimate responsibility".

The multi-disciplinary team is a two-edged sword. It can be a very rewarding and effective way of working. Alternatively, conflicts about power structure may destroy the cohesion of the team and render it worse than useless. It is part of the psychiatrist's dilemma to walk the tightrope between being too rigid and authoritarian on the one hand and abdicating his role on the other. There are clear areas where the psychiatrist has particular expertise. These include diagnostic assessment, drug treatments and the management of the psychotic or severely disturbed patient. Unless a patient is referred particularly by a GP to a non-medical professional he or she should be assessed by the psychiatrist, who may or may not be personally involved in future management.

It is important for the psychiatrist to listen to others and recognise their expertise. Most psychiatrists will know less than social workers about community resources and less than psychologists about psychometric testing. Members of the other disciplines may have more skill and training in behaviour therapy, family therapy, individual and group psychotherapy than the psychiatrist. While the psychiatrist carries medical responsibility, the clinical responsibility of other mental health professionals must be acknowledged. Disputes between psychologists and psychiatrists have been likened to marital conflict[2] and the experience of working in a multi-disciplinary team, like a marriage, can depend on the work the members are prepared to put into the relationships that constitute it.

## References


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