THE CONSULTANT, ONE WHO CONSULTS (AN ORACLE)

'An oracle—a response often ambiguous or obscure given by a priest at a shrine' (Dictionary definition)

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This article is based on a paper given to a meeting of the Chiltern and Thames Valley Division of the College. It discusses the document provided by the College called 'The Responsibilities of Consultants in Psychiatry within the National Health Service'.* The need for such a document probably reflects the current uncertainties and anxieties of many consultants and an awareness of their changed role in the health service and in society in general.

The first part of the document describes the background of a consultant's training and relationship to the General Medical Council and the Courts. There are only two matters that require further comment. The first lies in the problems posed by junior doctors and doctors in training. Although in law the consultant has no responsibility for his junior staff, in practice most consultants feel a keen sense of responsibility for them, their training, their background and their competence. There can be significant differences of opinion between a consultant and his juniors. Some consultants have found themselves with junior staff whose behaviour or mental state has caused them grave concern. They may be working with such a junior doctor for months, and feel that he is unsuitable for his professional work, but he may be totally unwilling to accept advice or guidance in any way. The document does not mention problems of this kind nor give sufficient help to consultants who may be uncertain about their responsibility for warning other colleagues, for providing a reference, or for the immediate safety of patients.

Towards the end of the first part of the document there is a surprising comment where it is suggested 'the employer has limited control over the professional opinions of the individual consultant'. It is not at all clear why this particular phrase has been inserted, as most consultants would feel that the employer had no control whatever over professional opinions.

The paragraphs headed 'Multidisciplinary Functioning' are probably the most likely to lead to further discussion and controversy. No attempt is made in these paragraphs to explain the essence of multidisciplinary functioning, though some comments are made which are potentially misleading. For example, it is said that some think of it as a democratic way of arriving at the best method of treating patients. If by 'democratic', is meant that all those present should feel free to comment upon the matter in hand and freely express their opinions then this would be acceptable. If, on the other hand, by 'democratic' it is meant that all those present would have a right to vote on any particular issue then this would be unacceptable to the very large majority, and indeed I do not know of any multidisciplinary group which uses this approach in dealing with the treatment of patients. Similarly, it is suggested that multidisciplinary functioning gives the status of equality in all matters to each member of the team. This, too, confuses the issue. At no point are all the members of the team equal. In discussion each member of the team contributes his own individual opinion and proposes what he or she feels his/her profession can offer in patient care. However, when it comes to determining the diagnosis, writing the prescription or giving a prognosis the doctor must accept full responsibility after discussion with his colleagues. Similarly, in deciding on nursing care, the development of appropriate nurse/patient relationships, the general management of the day-to-day life on the ward, the nurse would take responsibility and give a final decision. Similarly in terms of social work commitment, the relationship between the social worker, patient and relatives, the organization of home helps or other social service assistance, the social worker must take the responsibility and come to a final decision.

The document points out, correctly, that there are significant differences between the type of decision making at an administrative level, for example as it occurs at the District Management Team meeting and that which occurs at a ward meeting when the treatment of the individual patient has to be decided.

The document criticizes the need for a regular meeting of all the disciplines in deciding on the pattern of care for the patient. It says specifically that it is not necesaary to follow one method, i.e. by having a meeting, to achieve good communications. It is very difficult indeed to see how effective communications and agreement on a pattern of care can be achieved unless there *is* a meeting of those concerned. Most doctors have had bitter experience of the failures of communication when meetings are not held. It is notorious that arrangements over the telephone, by notes, or as a result of passing messages from one staff to another sooner or later lead to misunderstandings or failure of communication. As

* *Bulletin*, Sept. 1977, pp 4–7.

the document points out, even when meetings *are* held they do not necessarily achieve the expected results. This failure often lies in the training or personalities of those involved, and in this respect the consultants are as likely to be at fault as any other member of the team.

The College's document rightly points out that there are many problems when the hierarchical management of some disciplines, for example the nurses, can lead to a veto of decisions made at ward level. Too little, however, is said about the problems posed when one profession simply does not co-operate with the others or does not accept the need for some kind of multidisciplinary programme. Some consultants are indeed diffident about exposing their skills and competence in a multidisciplinary setting. Some social workers have concepts about mental illness which may make co-operation in treatment programmes very difficult, some nurses may be reluctant to accept the full significance of responsibility for their own professional actions, and although all of these attitudes occur, and resolution of the problems is possible, the document makes no specific comment about them.

It is difficult to understand the paragraph which suggests that multidisciplinary management is an option. One would like to know what the other options are. The old management policies when the consultant was in a position to tell other disciplines what to do, ceased once administrators, nurses and social workers became members of independent professions. There can be many variations on multidisciplinary management, some more efficient than others, and there is no doubt that if one member of the team is frankly hostile to the concept he can make it almost unworkable. This does not alter the fact that in the state of the present relationship between the professions, unless a doctor can do all the treatment himself multidisciplinary management is the only practical policy available.

The responsibilities of the consultant are listed, and it is here that one must query some of the phraseology. For example, when treatment is mentioned presumably it means that the consultant is responsible for *medical* treatment, as under present conditions he cannot be responsible for nursing or social work treatment. In some paragraphs treatment is mentioned, in others clinical responsibility. Is clinical the same as medical? In some paragraphs care is mentioned—it is not clear whether this means medical care, the caring attitude or nursing or other sorts of care. That a consultant should have a caring attitude is necessary but not that he should be responsible for nursing care.

The paragraphs which state that the consultant has a responsibility to the community he serves are to be welcomed. Indeed in this respect psychiatry has given other parts of the medical profession a significant lead. Similarly, everyone should support the paragaphs which suggest that he should take a lead in training his junior staff and other professions with whom he is in contact, but one would like to have seen some mention that he should be willing to listen to the opinions of others and learn from the other professions when they speak with authority on their own activities. The idea that a consultant always has to be the leader of a team may sound very agreeable to the consultant, but it is not always acceptable to other professions. For example, should he always be the leader when the team is meeting in the Health Centre or in the Local Authority Area Social Work offices? Should he be the leader when nurses are discussing the nursing organization of the patients' day? Should he be the leader when the problem under discussion is the social work service to one particular part of the catchment area?

The proposed paragraph 10 of his responsibilities uses an interesting phrase. It suggests that the consultant is the 'arbiter' in the care of patients. The usual understanding of an arbiter is that he is a person chosen by parties in a dispute, to decide between them. The consultant is very rarely in this position, and indeed where there is a disagreement he is likely to be one of the parties. For example, should he be the arbiter if there is disagreement on the need for admission of a frail elderly person under Section 25 late at night, when the social worker feels that better arrangements could be made outside hospital? Even in situations where it is usually assumed that he is able to make a final decision the reality may prove different. For example, it is usually assumed that the consultant will decide on the admission or discharge of a patient. Recent events, however, have shown that it can well be nurses who will make a final decision on whether a particular patient is admitted or not. In many situations the consultant should have a major say in the development of overall policies but other individuals will implement them or should have the final word on immediate and day-to-day decisions.

One would have liked to see in the College's document some statement to the effect that the consultant has responsibility for developing and maintaining good relationships with his colleagues and other disciplines.

Lastly it must be recognized that the vast majority of psychiatric consultants have been practising a multidisciplinary approach for many years and recognized it as good practice long before the phrase became fashionable.