

The task of treatment and the multidisciplinary team

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Treatment and its subsystems: case management and therapy

Throughout society there is an increasing tendency to approach the various activities of human existence in a way which eschews blind acceptance, but requires instead thorough examination and analysis of the processes involved in those activities in the belief that the insight gained will improve performance. Treatment is a central activity of the Health Service, and this paper will attempt an analysis of the processes involved in it within the context of the clinical team delivering it.

We may conceptualise treatment as a human activity system, belonging within the Service Systems group on Checkland's (1971) Classic Systems Map. It meets all the necessary criteria for this, as it consists of two or more components (doctor, nurse, patient, tools, drugs), arranged in particular ways, i.e. doctor/patient rather than John/Jack, and this arrangement has a goal (the restoration of the patient to health) (see Fig. 1).

If *treatment* (linguistically the widest term) is a system comprising the sum total of activities aimed at restoring patients to health, those activities can be seen to fall within two groups. There are activities which attempt to alter the environment and circumstances of the patient, e.g. admission to and discharge from hospital, aftercare, Court reports, housing recommendations, case conferences. These form the subsystem of *case management* and their function is to optimise the circumstances for success of another class of activities which aim to produce change by direct input into the patient. Those second form the subsystem of *therapy*. Both these subsystems concern themselves with problem-solving and therefore share those processes that are common to all problem-solving exercises: i.e. data collection, theorising – shaping the information into insights and application of insights into action for change.

They also differ in a number of ways. Case management is mainly concerned with decision-making, which means choices and therefore requires width of information, width of theoretical possibilities and a good variety of available methods for intervention. Therapy, however, is mainly concerned with application of skill and requires depth rather than width in collecting data relevant to the skill, in forming a related hypothesis and in the actual method of its

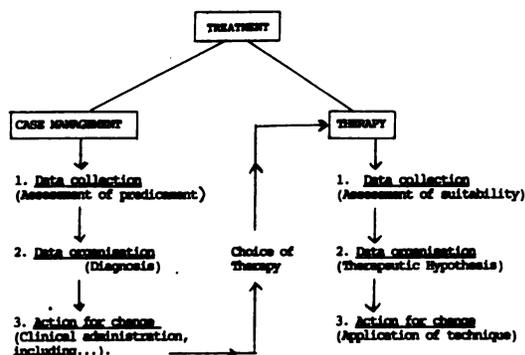


FIG. 1 Flow of tasks within treatment.

delivery. The two subsystems are linked by the operation, commonly known as choice of treatment (a definite misnomer of what is in fact choice of therapy), which belongs to the case management subsystem, and leads into the therapy subsystem.

The above analysis of the processes of treatment points to the existence of tasks which need to be performed within the two subsystems of case management and therapy by various professionals and to varying extents. The health team has always been multidisciplinary, the number of disciplines increasing as more were created to perform specific tasks, when the need for delegation of such tasks arose. Think of the evolutionary development from the doctor and the nurse, to the surgeon, the theatre sister, the anaesthetist, the physiotherapist. Relatively recently, multi-agency networks were created to make it possible for the school doctor to advise the educationalist, for the geriatrician to advise the social services department, and vice versa.

When the various disciplines were created in order to perform specific tasks, it seems surprising that discussions of the multidisciplinary team appear to have taken place in the absence of any analysis of those tasks (Rowbottom & Hey, 1978; Interdisciplinary Standing Committee, 1981; Overtweil, 1986). Instead attention focused on legalistic issues, e.g. responsibility and accountability, organisational themes, e.g. primacy, leadership, and even political matters, such as autocracy or democracy. Some of these may be obvious – everybody has a responsibility of care, and failure to discharge it constitutes negligence. Others are almost irrelevant (all organisations have relative

amounts of autocracy or democracy built into them), while others may only be defined by their task content, e.g. leadership, autonomy, and as regards accountability, one is accountable only for what one is expected/contracted to undertake.

Treatment tasks and professional briefs

In examining how treatment tasks translate into professional briefs, it is perhaps easier to start with the therapy subsystem; within this the therapist, who can be anyone with a specific skill, from psychotherapist to dietician, addresses only one managerial question: "Is there sufficient congruence between the patient's predicament and my skill for the two of us to engage in the therapeutic method I can offer?". This decision is reached by the collection of data relevant to the skill in question, e.g. food intake for the dietician or family dynamics for the family therapist. On these same data a particular insight will next be formulated and therapeutic action follow. In this way the three stages of problem-solving will have been tackled. Therapists of appropriate competence can expect to enjoy autonomy for the performance of their skill, hopefully subject to audit by peer therapists, who use the same method, whatever their professional provenance. This is obvious with some therapies, such as nursing or speech therapy, which are specific to professions, but becomes an important issue with therapies such as behaviour therapy (offered by psychologists, nurses, doctors *et al*) or psychotherapy (offered by doctors, lay therapists, psychologists etc.).

The case management subsystem calls for tasks of a very different flavour. In the multidisciplinary context, information is generated by numerous people in different forms, e.g. pathology lab reports, psychological tests, dietary assessments, social reports, interviews with relatives. Almost all members of the clinical team have an assessing brief, and are expected to provide formulations. Based on the advice received the theorising operation takes the form of diagnosis, where the data are evaluated, compared and selected for or against, probabilities are weighed-up and alternatives excluded by the case manager, who is the clinical consultant. He/she then proceeds to direct therapy and initiates the necessary activities of clinical administration. This is because the clinical consultant possesses the necessary width of knowledge base for the performance of this task, and not because of his/her medical status. To illustrate the point, the microbiologist, radiologist or EEG specialist consultants all have an assessing brief, but only a limited diagnostic and no therapeutic or clinical administrative briefs.

One of the most significant decisions of the case manager is the choice of therapy, which depends on a number of factors, the most obvious of which are:

- (a) the patient's problem
- (b) the availability of skills (both whether they exist and when they will be available)
- (c) the assets of the patient and his circumstances
- (d) economics (time and cost v. hoped-for results)
- (e) the patient's choice (expressed in complaint, compliance, even subjective improvement).

These tasks of case management are the remit of the clinical consultant only for the purposes of the patient's health. In multi-agency situations, such as with the old child guidance teams and the emerging psychiatric community teams, there are areas where the doctor's task is limited to assessment only. On care issues or when special educational needs are concerned, social services and education respectively have the managerial role, with the clinician advising. The same principle applies to diagnosis; borrowing more examples from my own field – autism is a medical and not an educational diagnosis, but maladjustment is the opposite. Sexual abuse is a legal/social diagnosis, while emotional disorder as a result of sexual abuse is a medical one. Failure to acknowledge these principles and the presumption of an overall managerial brief has resulted in major difficulties for child psychiatrists in multi-agency situations in the past. However recognition of our limits should help us avoid the same mistakes now that multi-agency community teams are proliferating.

Some warnings

There is currently a degree of experimentation with service delivery, and a number of models are being tried which take short-cuts through the processes described with potentially dangerous consequences. One example is the general practitioner who refers directly to a therapist. This assumes that the diagnosis has been made by the GP who has also chosen the therapy and in fact the therapist. If this is really so, there is no problem. If, however, therapists, typically psychiatric nurses, are expected to diagnose and manage cases, then they are being given tasks which have no brief to perform, and for which they cannot be held accountable. Even more fraught is the situation where under an assumed open access system, a patient self-refers to a therapist with no diagnostic potential, e.g. a mother who takes her hyperkinetic child to a behaviour therapist. In such a situation, case management is totally by-passed, there is no multi-faceted assessment, no diagnosis and quackery is just around the corner.

Postscript

This analysis of tasks involved in the operation of the treatment system and its implications for

multidisciplinary teams does not expect to answer all questions which such teams face in operation. It cannot take into account the idiosyncracies of real teams. All it purports to do is to present a task-based framework and point to the resulting boundaries and limits. In doing so, it risks dissatisfying almost everybody, since the acceptance of boundaries is generally emotionally unwelcome, yet notions of omnipotence or omniscience have little place in professional reality. On these last two words the case rests.

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NHS indemnity for medical negligence: its implications

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From 1 January 1990 medical and dental practitioners employed by health authorities were no longer required under the terms of their contracts to subscribe to a medical defence organisation. The health department, however, advised practitioners (DHSS circular) to "maintain their defence body membership in order to ensure they are covered for any work which does not fall within the scope of the indemnity scheme". The expediency with which the scheme was introduced enabled little discussion on the consequences of such change and surprised medical practitioners and defence organisations alike. This major change in medical indemnity since 1954 will have long-term implications for practitioners, medical defence organisations, local health authorities and most importantly, the quality and quantity of health care which can be delivered. A meeting held on 9 April 1990 at Charter Nightingale Hospital was convened to discuss the implications of the NHS indemnity scheme between senior registrars in psychiatry and representatives from the Medical Defence Union, Medical Protection Society, British Medical Association and the local health authority.

Why the change?

From 1954 until 1 January 1990, health authorities have had a vicarious relationship with their prac-

tioners concerning medical defence (HM 54 32). The last 10 to 15 years have seen steeply rising subscription premiums to defence organisations, resulting in the introduction of competitive and differential premiums. The effect of such changes on recruitment to various medical specialties was buffered by the introduction of two-thirds reimbursement of defence body fees by the health authorities in 1989. However, within a year of this change the health secretary, with great expediency, introduced the NHS indemnity scheme from 1 January 1990, with most practitioners receiving notification of this change in November/December 1989. Limited negotiations had taken place between the health department and the defence organisations and it was clear from this meeting that they were critical of such a scheme being able effectively to deal with the rapidly rising claims for medical negligence. Of much more concern were the effects of such a scheme on the finances of local health authorities and the necessarily altered relationship with their practitioners. All representatives were in agreement that practitioners should continue with a basic medical subscription. Medical work not covered by the NHS indemnity includes any private work, good samaritan work, locum sessions in general practice and any legal work such as prison visits, solicitors' reports and