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Audit in practice

Teamwork and satisfaction: the team member's view of multidisciplinary teams

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The responsibility for patient treatment is shifting from physician to non-physician professionals throughout medicine. Multidisciplinary teams are replacing hierarchical structures in which the consultant is dominant, particularly in disciplines which care for patients suffering from multiple or chronic disabilities.

There are a number of problems inherent in multidisciplinary teams (Soni *et al*, 1989). Recurring themes include issues of accountability and leadership (Cockburn, 1989). A team leader, a clearly defined team leader role and agreed authority are essential to the success of a team (Ovretveit, 1990). But who should be the leader and what should be the role of the consultant?

The Royal College of Psychiatrists has issued a statement of policy regarding the consultant's responsibility within the framework of multidisciplinary teams (Royal College of Psychiatrists, 1977). It recommends "a standardized pattern centring on a regular meeting on the ward of all disciplines". But "the legal, professional, ethical, diagnostic and prescriptive responsibilities of the medical profession cannot be delegated to a multidisciplinary group when treating an individual patient ... Multi-disciplinary in this context, from the medical point of view, is a process of consultation, the final decision resting with the Consultant on matters where the Consultant has the final responsibility."

In-patient psychiatric care in the Guy's and Lewisham Trust follows this pattern. Care is provided by a multidisciplinary clinical team in which consultants hold primary responsibility for in-patients. All consultants meet with other members of the multidisciplinary team at least once a week.

We wished to assess the multidisciplinary teams by evaluating the team meeting with respect to members' reported level of participation and members' satisfaction with their team.

The study

The audit was performed on the ten consultants providing acute in-patient care to general adult or to elderly psychiatric patients in the Guy's and Lewisham Trust. We identified the senior member of each non-medical discipline and the junior medical staff who attended the principal weekly meeting for in-patient management, such as the ward round. This comprised nurses working on the in-patient unit, community psychiatric nurses, social workers, occupational therapists, art therapists, psychologists, senior house officers and registrars. They were asked to fill in a forced choice questionnaire about the way in which their multidisciplinary team meeting functioned, with emphasis on the consultant's level of consultation and discussion with other team members. Respondents were also asked whether they were satisfied with the work of their multidisciplinary team. To ensure anonymity, members were asked only to state which team they were attached to, not their name or discipline. All participants were promised a summary of the results after completion of the survey.

Questions covered by the questionnaire were:

Q1. Who attends the principal management meeting of the week (e.g. the ward round or 'wardex')?
Q2. Do you report on your contact with your patients, at the meeting?
Q3. Does the consultant take proper notice of your contribution to the formulation of plans for patients?
Q4. Are you actively involved in contributing to patient assessment, management and discharge plans, in the meeting?
Q5. Does the consultant discuss or explain the reasons for his/her decision?
Q6. Do you feel satisfied with the work of your ward multi-disciplinary team?

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In response to each question, subjects were given the forced choice of 'always', 'often', 'sometimes' or 'never'. Space was allowed for clarifying comments.

Two questions asked for comments only:

Q7. How do you assess your satisfaction?
Q8. Do you have any other comments about your multidisciplinary team work?

We agreed that an acceptable standard for the audit would be a response of 'always' or 'often'.

Findings

On initial enquiry, staff were enthusiastic about the study. Fifty-seven questionnaires were sent out and there were 42 replies (a 74% response rate). The differential in response to individual questions suggested that the questions tapped different aspects of the team meeting. The comments section was used by respondents to explain their ratings, and did not suggest any other aspects of the consultant's performance that we should have taken into account.

All teams comprised at least three disciplines in addition to medical staff. (We regarded community psychiatric nurses and ward nurses as distinct.) The modal number of non medical disciplines attending psychogeriatric ward team meetings was 4 (range 3–4) and the modal number attending adult general psychiatry meetings was 5 (range 4–7).

The overall response of team members to the questions relating to the consultation of staff by consultants (questions 2–5) was broadly positive; 8.9% of responses were 'sometimes', 31.6% 'often' and 59.1% 'always'. (0.4% of questions had no response.) The question on satisfaction with work (question 6) received a uniformly lower rating; 10.7% of responses were 'sometimes', 67.5% 'often' and 15.8% 'always'. (6.0% of questions had no response.)

The aggregate scores achieved by individual consultations were not significantly different. Nor did respondents' comments reveal any obvious differences between different teams. However, in general the psychogeriatric teams achieved higher scores than the adult psychiatry teams. Although the comparison of mean scores did not reveal any significant differences, when the raw scores were considered, psychogeriatricians scored 18 'always' scores compared with 6 in other categories. Adult general psychiatry scored 70 'always' scores compared with 84 in other categories. The psychogeriatric teams had a significantly greater frequency of 'always' responses than the adult psychiatry teams (χ^2 test $=6.12$, $P>0.05$).

Comments

The enquiry of our medical audit focused on the activity of the consultant within the setting of a multidisciplinary team meeting from the perspective of the other team members. The results of the study indicated that consultants' performance, as judged by their team members, almost always reached the standard that we had set of 'always' or 'often' consulting the other team members and discussing patients' care with them. The study suggests that the consultants are making appropriate use of multidisciplinary expertise. However, it may be that consultants achieved high scores only because they satisfied the team members expectations. Satisfaction with the meeting may not reflect a 'true' multidisciplinary approach, but a team that has found a *modus operandi* that suits all of the members.

The higher scores obtained by the psychogeriatric consultants may reflect the fact that these consultants had been working in the community with multidisciplinary teams that work in a non-hierarchical way, for between two and six years (Coles *et al*, 1991).

The respondents' general satisfaction with the work of their ward multidisciplinary team (Q.6) was always lower than satisfaction with the meeting and with the consultant in that meeting (Q. 2,3,4,5). The comments in response to the question 'How do you assess your satisfaction with the work of your ward multidisciplinary team?' were diverse. Some respondents mentioned the functioning of the team meeting, but available resources, efficiency, and general communication with other members of the team were also considerations. The way the team meeting functions need not necessarily reflect the overall functioning and efficacy of the team, or its delivery of care.

Conclusion

One measure of outcome of a service is the satisfaction of those who use the service (Donabedian, 1988). In this study we elicited the views of staff of multidisciplinary teams.

Multidisciplinary teams are increasingly used in psychiatric care, but there is still controversy as to how they should be run. In the view of the College, the leader of the multidisciplinary team must be the consultant, but team members must be consulted. Our audit of staff views of their multidisciplinary team meeting indicated that all consultants either often, or always, actively and effectively consulted with the other team members. Psychogeriatric consultants scored higher than the adult psychiatric teams.

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Future lines of enquiry should include an objective analysis of the work of individual members, and satisfaction questionnaires regarding aspects of their work outside of the team meeting.

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Psychiatry of learning disabilities

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Medical audit has become an overt part of our work over the last few years, hastened by the 1989 White Paper. At a meeting on 1 November 1989, the mental handicap psychiatrists of Bristol and Weston, Cheltenham, Frenchay, Gloucester, and Southmead Health Authorities agreed to meet monthly to audit agreed topics in mental handicap across district boundaries. These meetings were to be in addition to any local district audit that may already have been occurring, and were to provide a peer group for audit and a means of cross-fertilisation of ideas for projects. The group has now operated for over two years, and would like to present some examples of the topics covered and some comments on its experiences to help stimulate correspondence in the *Psychiatric Bulletin* on medical audit in learning disabilities.

The study

Anticonvulsants

The initial standard set was that all patients with epilepsy should be maintained with clinically acceptable seizure control on one anticonvulsant. The in-patients on more than one anticonvulsant were looked at in the group and the consultants asked to justify the therapy. In addition, an initial blood monitoring standard was agreed of six monthly checks of drug levels, full blood count [FBC], liver function test [LFT] and urea and electrolytes [U&E], with three monthly U&Es for patients on acetazolamide.

The follow-up meeting again peer reviewed patients on polytherapy. The blood monitoring standard had so universally failed that no-one felt able to assess its merit! We discovered that we had to improve our routine call-up systems and felt we should still aim at the six monthly standard. The third meeting of the cycle found this still to be a major failing, which was frustrating as many of the blood tests available were abnormal. This cycle looked at fit control as well as polytherapy, and suggested that patients having more than ten seizures in six months should have their therapy reviewed before the next meeting in the cycle.

Down's syndrome

The initial meeting discussed what baseline and routine ongoing screening each district performs and their apparent value. It was agreed to set an initial minimum standard of an annual check of thyroid function, FBC, U&E and LFT. There was indecision on how frequently routine physical examinations should be done.

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