Editorial

Team working, then and now

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Team working is not new. In 1878 Surgeon-Major Evatt (later Major General Sir George Joseph Hamilton Evatt) described the ward round in an army hospital in India:

"When a medical officer starts from the hospital office in the morning to visit his wards, he finds waiting for him at the door of the ward the medical subordinate, a compounder carrying a box of medicines, a dresser holding stethoscope and pocket case, an orderly from the regiment exercising an ill- defined power over patients and ward coolies, a bhistee (water carrier) holding a basin of water with towel and soap, a cook with a piece of chalk in his hand to mark the leg of the patient's bed with their diet, a wine-wallah to note the need for beer and wine, two ward coolies who may or may not be present and who know little or nothing about their wards and their patients and, by the door in a half-hiding way, the ward mehter or sweeper. The medical officer makes his visit and orders a new diet. The cook marks the leg of the bed, and the wine-wallah notes the wine. If the medical officer wants to wash his hands, the bhistee brings the basin and towel. If he wants to see any de-jecta or even sputa, all the servants stand aside for the sweeper, who alone will show him them; if it be a case of bronchitis, the dresser advances with the stethoscope. The compounder, if it be wanted, gives the caustic solution. The orderly hands the diet cards, and thus the vast machine creaks on."[1]

The names of the personnel have changed (who should be the wine-wallah of today?) but we still have doctors, nurses, specialist nurses, pharmacists, Macmillan nurses, dieticians, physiotherapists, occupational therapists and bed managers, each with a role to play. However at the risk of being politically incorrect I would venture that there are aspects of medicine where team working is not always productive. Take history taking. On the medical admission unit so many presentations are not due to physical illness at all but to circumstances at home; bereavement, marriage breakup, lack of access to friends or grandchildren, the stress of looking after an ill spouse and - most common of all - loneliness. The patient may not recognise this. History taking is time-consuming and has to be done one to one and at the patient's pace. It does not lend itself to being done by a team. GPs are (or at least were) taught to do it and did it well in the privacy of the consulting room but with their energies increasingly diverted elsewhere they may no longer have time. There are those all important open ended questions: "*and is there anything else?"*. The question is important, but so also is the pause after. It's difficult to do all this with a retinue behind impatiently looking at their watches and with their bleeps going off.

It also doesn't work well with patient lying in bed while we stand over them. I read recently how we are quite happy to sit down at eye level when we communicate with our computers but not with patients. Why not? If we really believe MRSA sticks to our bottoms when we sit on the bed then we must get a chair, or - as one American professor does - get an underling to carry a chair for him. Perhaps the chair-wallah could join the ward round instead of the wine-wallah (why not both?). I am sure a controlled trial of sitting on patients' beds talking to them at eye level would show just how much more history and reassurance is achieved, so speeding diagnosis and shortening length of stay. The "do not sit on bed" rule and the sad abandonment of hospital flowers are probably the most significant casualties of MRSA.

Michael Balint's book *The Doctor, His Patient and The Illness*, introduced the idea of the "drug doctor" and showed the powerful effect of helping the patient recognise what it is that is making them feel ill. He

also coined the phrase a "collusion of anonymity". It's a real problem today with patients bouncing from multidisciplinary team to multidisciplinary team with months passing without treatment with increasing uncertainty and no one taking responsibility. We each do it in our speciality: "*the endoscopy is normal I would like you to see a cardiologist*" - "*no your heart is fine. I will ask the chest doctor to see you*". It's bad medicine. All the time anxiety grows and the deep underlying psychological cause for the patient's symptoms gets lost beneath layers of tests and procrastination. We must step back. Concentrate on the singer not the song and, to paraphrase Des Spence, listen to the soft rock music of patients' lives. The lyrics may be the same: chest pain, headache, gastrointestinal bleeding, but the music is different in every patient and if we treat the lyrics without listening to the music we fail. My criticism of modern medicine is that it has no ear for the music; and just sometimes it is the background noise and clamour of our well intentioned multidisciplinary teams that blocks out the still quiet music we are listening for.

Much of this overlaps with dignity in care and the report of the Commission on Dignity in Care has recently reported, and rightly seeks to ban patronising language such as "bedblocker" but also riles at the use of the term "dear" which I have to say I rather like.[2] At least we don't call patients "Muppets" as Goldman Sachs refer to their clients, but even "Muppets" has a rather warm engaging connotation. Does it matter what we call our patients? Again a quote from Balint: "understand your patients if you can, love them if you must but for heaven's sake notice them".[3] What we call them is not of great importance (provided it is not "client", a term which should be reserved for those served by solicitors, prostitutes and – of course - Goldman Sachs' Muppets). Maybe a dignity champion should join our chair-wallah on ward rounds to put us right.

Our teams are different from those in Surgeon-Major Evatt's day, but are still there and just as large. Each member of the team has an important part to play but we must be on our guard not to hide behind the anonymity of the team and at all times be wary of anything that interferes with the sacred rite of communication between the doctor and his or her patient.

Of relevance to the above are two parodies of very different doctors. Which do you prefer?

Give me a doctor partridge plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands
Who never makes absurd demands
That I abandon all my vices,
Nor pulls a long face in a crisis,
But with a twinkle in his eye
Will tell me that I have to die.

WH Auden

or

Give me a doctor underweight,
Computerised and up to date,
A businessman who understands
Accountancy and target bands,
Who demonstrates sincere devotion
To audit and to health promotion,
But when my outlook's for the worse
Refers me to the practice nurse.

Marie Campin retired London GP[4]

Lastly it has been a pleasure to have been involved with the Darlington Medical Journal for 30 years. I would like to praise Richard Henderson and the other members of the committee for all the work involved in keeping it in the healthy state it now enjoys and I wish it well for the future.

1. Evatt GJH Notes on the interior economy of army hospitals in India Indian Medical Gazette 1878; 13,34
2. The Commission on improving dignity in care. Draft recommendations http://www.nhsconfed.org/priorities/Quality/Partnership-on-dignity/Pages/Draftreportrecommendations.aspx (accessed 16/3/12)
3. J Norell. Balint medicine. J R Soc Med 1993; 86:435-36
4. Quoted by Clare Bates Clin Med 2001;1: 128-31

Peter Trewby recently retired, and sadly has stepped down from the Editorial Committee. We are pleased however that he agreed to write this farewell editorial and we all wish him well in his (active) retirement.