

From Omnipotent Doctor to Multidisciplinary Team

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Has there been any impact on Patient Care?

So what is HISTORY?

The slide shows it is

- Study of past events, especially human affairs
- Eventful past career

We often look well back into the past to illustrate a point but I have decided to use more recent New Zealand history, partly because we have access to the wonderful collection of images which Ron Easthope has gathered and partly because I know far more about events during my own career, and to some extent that will mirror your own.

And of course what we once did is now well and truly history!

The genesis for this talk came in 1989 when I talked at a Rehabilitation Conference about the changing roles of health professionals, particularly in regard to the workings of the Multidisciplinary team and the aging of the health professionals themselves. As a result I was invited to talk at the Inaugural meeting of the District Nurses Conference in Napier. The nurses had heard me comment on their own changing roles, and hoped that the messages about the other professionals could be more widely spread.

So now here is the third version of those ideas.

In the past THE DOCTOR was seen as having total authority. There had always been an elite group, mainly men - after all it was called the medical Fraternity - of DOCTORS who were learned, wise, authoritarian and who often passed from father to son or to their students , **the knowledge and the power because of their superior ability to think and learn.**

There was a HIERARCHY within that, and there was respect, but there was also OMNIPOTENCE and therefore POWER.

Something has happened in the last 50 years in and to the medical profession to change that perception.

If we look at a few examples of omnipotent or powerful doctors we could start with **HIPPOCRATES**. He was an ancient Greek Physician born c.460 BC died c.370 BC, established medicine as a profession. The Hippocratic Oath is attributed to him, although it may have been formulated 100

years after him. Has been described by some as “Meaningless relic or invaluable guide”. We will look at it a little later.

A few centuries later there was **MAIMONADES**. He was also known as Ramban. A 12th Century Spanish Sephardic Jewish philosopher who was also an astronomer, Torah scholar and physician. He became Physician in the Muslim Court in Egypt.

In the 17th century we could look at **Le Medecin du Village**. This etching hung in my father’s surgery. He had brought it from Berlin. I had it hanging in mine until 1977 when I moved to hospital work. It is an etching by Jacob Folkema (1692-1767) who copied a painting done in 1659 by Casper Netscher (1639-1684). Quite different from pictures hung in surgeries these days.

Warren Pixer says it was common for paintings then to have etchings made which “gentlemen” used to show at special evenings. May have been the origin of the phrase come and see my etchings!?)

JOHN HUNTER well known to this group is shown here with the book and the skeleton in similar fashion to the last doctor.

I was looking for a more recent example and remembered hearing about **BLIN BULL**. Here he is. The combination with the Army uniform adds to the aura. He had been a POW in the second world War and later Director Medical Services Army and Air. He was a surgeon at Wellington Hospital

Then I read about his predecessor **SIR FREDERICK BOWERBANK** and have included him

LOUISA MARTINDALE Surgeon 1872-1966 Physician Surgeon Writer Magistrate and member of NCW Also had children Louisa and Hilda. Described as FORMIDABLE.

From earliest day doctors realised that with the authority must come accountability. For hundreds of years the Hippocratic Oath has been a cornerstone of the profession

Hippocrates and the Oath. It has been revised several times.

The version for 1957 for my Graduation;

“I solemnly declare that, as a Graduate in Medicine of the University of New Zealand, I will exercise my profession to the best of my knowledge and ability for the good of all persons whose health may be placed in my care and for the public weal.

I will respect the secrets which are confided in me and maintain the utmost respect for human life. I will hold in due regard the honourable traditions of and obligations of the medical profession and do nothing inconsistent therewith and I will be loyal to the University and endeavour to promote its welfare and maintain its reputation.”

It is encapsulated in the often quoted “Primum non nocere” First do no harm.

Not everyone can have been happy with the Hippocratic Oath, as more declarations followed.

THE OATH OF MAIMONADES more a prayer really.

Maimonides also known as Ramban was a 12th century Jewish Egyptian Physician. The following Oath, or prayer, has long been attributed to him, but may in fact have been written by a German physician, Herz, who was the first to write it out. Even though the true author may not be known it is interesting that another version of a “medical oath” exists.

- "The eternal providence has appointed me to watch over the life and health of Thy creatures. May the love for my art actuate me at all time; may neither avarice nor miserliness, nor thirst for glory or for a great reputation engage my mind; for the enemies of truth and philanthropy could easily deceive me and make me forgetful of my lofty aim of doing good to Thy children.
- May I never see in the patient anything but a fellow creature in pain.
- Grant me the strength, time and opportunity always to correct what I have acquired, always to extend its domain; for knowledge is immense and the spirit of man can extend indefinitely to enrich itself daily with new requirements.
- Today he can discover his errors of yesterday and tomorrow he can obtain a new light on what he thinks himself sure of today. Oh, God, Thou has appointed me to watch over the life and death of Thy creatures; here am I ready for my vocation and now I turn unto my calling."

That's not the only one. There is also

THE DECLARATION OF GENEVA (Physician's Oath) was adopted by the General Assembly of the **World Medical Association** at Geneva in 1948, amended in 1968, 1983, 1994 and editorially revised in 2005 and 2006.

The Physician's Oath

At the time of being admitted as a member of the medical profession:

- I solemnly pledge myself to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude which is their due;
- I will practice my profession with conscience and dignity; the health of my patient will be my Number One consideration;
- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession; my colleagues will be my brothers;
- I will not permit considerations of religion, nationality, race, party politics, social standing, or sexual orientation to intervene between my duty and my patient;
- I will maintain the utmost respect for human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity;
- I make these promises solemnly, freely and upon my honour.

The Declaration of Geneva, as currently published by the WMA World Medical Association^[6] reads: (nearly the same as above)

At the time of being admitted as a member of the medical profession:

- I solemnly pledge to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude that is their due;
- I will practice my profession with conscience and dignity;
- The health of my patient will be my first consideration;
- I will respect the secrets that are confided in me, even after the patient has died;
- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
- My colleagues will be my sisters and brothers;

- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honour.

While we are looking at the pledges to service it is worth noting the **NIGHTINGALE PLEDGE** which Florence Nightingale developed for the nursing profession. It is an adaptation of the Hippocratic Oath.

Original Florence Nightingale Pledge 1893 revised in 1935

"I solemnly pledge myself before God and in the presence of this Assembly to pass my life in purity and to practise my profession faithfully.

I shall abstain from whatever is deleterious and mischievous, and shall not take or knowingly administer any harmful drug.

I shall do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling.

I shall be loyal to my work and devoted towards the welfare of those committed to my care."

With loyalty will I aid the physician in his work," added in 1935

IN THE COURSE OF OUR TIME IN MEDICINE there have been many major changes.

Changes in language e.g DS to MS, new drugs (all the antibiotics and hypotensives), new diseases (Aids), sexual health changes, new vaccines, new imaging techniques first CT then MRI then PET), new building strategies which impact on patient care (for dementia), joint replacements, the changing emphasis to value for money in the Health dollar (used to be written off, now is political), the new ways of teaching (computer), the rise of support groups (asthma , CORD, Alzheimers), the emphasis on preventive medicine (although it was taught as a subject when I was a student), AND the increasing reliance on Multidisciplinary teams.

Out of all the changes I thought a focus on MULTIDISCIPLINARY TEAMS would be interesting as it is less commercial and rarely discussed. AND I think it had a lot to do with the changing role of the doctor.

AFTER NEARLY 20 YEARS IN GENERAL PRACTICE in Upper Hutt for personal reasons I opted to return to Hospital work.

In 1977 Casualty Departments, Psychiatric Wards, Geriatric Wards, and sometimes Paediatric wards were taking experienced doctors on staff, designated as MOSS (Medical Officer Special Scale). The

Special Scale actually meant “we pay you less” ie about 20% less than the basic specialist pay and a more gradual increment for length of service. I privately called it MO Special Skill.

Thanks to the combined efforts of Keith **COCHRANE**, then Superintendent Wellington Hospital and Frank **HALL** then Acting Superintendent Silverstream Hospital, I took on a 5 tenths position at Silverstream Hospital. One tenth was for being on the night and weekend roster. I had Ward 1 first, one of the continuing care wards for women. Frank Hall carefully asked me if I had had many male patients before.

Yes I **had** I told him, and THEY had had a choice of who to go to.

The biggest surprise on returning to ward work was the change in staff attitudes and roles. I was now the Doctor who led the ward round, but there were other staff apart from the nurses who were present AND offered their opinions. Good ones too. Another surprise came when I did a Ward round in the men’s ward and one of the rather immobile old men sat up as briskly as he could and **SALUTED ME!** He was a war veteran and he KNEW that “the doctor” held the power and of course the rank.

Then I became Hospital Superintendent as well as having a ward, part of my first Multidisciplinary team. It was a Triumvirate, known as the **DIRECTORATE** with Doctor, Matron (now called a Principal Nurse) and an Administrator as the team who ran the hospital. Caleb Tucker who was Superintendent in Chief of all the 5 hospitals in the Region told me, and I’m sure he believed it, that THE DOCTOR bore the ultimate responsibility. I believed it too.

In 1982 when Verney **CABLE** retired I took over the Rehabilitation ward, Ward 6. Verney had been a well respected and important Senior Physician at Wellington Hospital. After the first ward round the Ward sister asked if I intended to be part of the team meeting. Why not, I asked. Well Dr. Cable didn’t believe in multidisciplinary team meetings. He told the ward sister what he wanted and she interpreted that for everyone else. Maybe when he was 80 plus he preferred to work alone. In his earlier years he had been a dynamic innovative doctor ready to take on challenges, but mostly to lead from the front. Frank Hall taught me that the best way was to lead from the back.

Another bigger surprise awaited me. The other clinical staff all had rehab experience and were very vocal. I had to earn my place in the team. I had good GP experience. A good GP can do anything! even be part of a MULTIDISCIPLINARY TEAM . I hadn’t even worked with a Practice Nurse. I was not used to taking anyone else into account except the patient, and maybe their family.

So to put THE TEAM into perspective.

**** Journal of Royal College of Physicians, Clinical Medicine Vol 14 No 3 dated 3/6/14 discusses the working of a multidisciplinary team when sorting out who should have a PEG inserted.

Paper written by Gemma Clarke Research associate; Sarah Galbraith Consultant in Palliative Care; Jeremy Woodward Gastroenterologist; Anthony Holland University Chair of Health Foundation; Steven Barclay University Lecturer GP and Palliative Care.

“A multidisciplinary team meeting provides a crucial space for **CLINICIANS** to come together and discuss the wider issues involved, in detail and in depth.”

This particular team was chaired by the Consultant in Palliative Medicine but include gastroenterology staff, geriatric staff, speech therapists, dietitians , clinical nurses, endoscopy nurse and the patient's primary care nurse.

So let's look at the Multidisciplinary Team as it was at Silverstream Hospital Rehabilitation Ward. The hospital was not really typical but the team was.

Should one start with the **Doctor?** Well we will today, but not all team members would have agreed with that.

In a Rehab Ward one might expect the doctor to be a Rehab Specialist. Well no, this one was an experienced GP. Not a problem provided everyone else was aware of that. Could we ask for help and advice from a "real" medical specialist. Yes we could and did, but then one was not omnipotent. Was the doctor the team leader? Had we had any leadership training or could we only lead from the front? Did being a sportsperson help? Did you play golf or Rugby? Otago took medical students on high marks, Auckland opted for interview as well. Did that make the doctor more suited to being part of a team?

How about the **Charge Nurse** next. Previously she was known as the Ward Sister. Now she was not only expected to run the Ward. She was part of the hospital hierarchy and often the only fully trained nurse in the ward. Was she hospital or polytech trained? Did she have postgraduate training? Was she a practical nurse or a theoretical nurse? What did the colour of her uniform mean? Where were the epaulets which I knew would give me a clue to her experience.

Should or could I ask her?

Missing from the photo but an important person on the team. **Physiotherapist.** Where had their previous experience been? Diploma? University qualification? In Hospital? Rehabilitation? Solo practice? Any postgraduate experience? We had a pool. Did they know about pool therapy?

NZ Society of Physiotherapists established in 1950. It is a professional body, the membership of which is optional but demonstrates that the member upholds certain standards and includes adherence to a Code of conduct.

The **occupational therapist** (OT) has come a long way since the days of basket making.

OTs assess and treat people who, because of illness, injury or circumstance are limited in their ability to undertake the activities of everyday life. (This can mean using a knife and fork, or a computer, or driving a car, or any other activity).

The OT Association started in 1949. It maintains standards and supports and represents OTs

There are 2 tertiary institutions, Otago and Auckland , Health Sciences Diploma and the possibility of Masters degrees

Social worker next. Maybe this was the biggest challenge. The Social Worker had evolved from the almoner of the past. Social Workers Board of Registration since 2003. This is a Professional independent body to hold practitioners to account. Can be Bachelor from a University or a Diploma

from Polytech. Some are “historic recognitions”. Probably the most diverse group of qualifications, or nonqualifications.

Came under the umbrella of legislation later in 2003

Most importantly they have a **Social Work Code of Ethics** and are expected to “protect client integrity by maintaining confidentiality” Because not all social workers are qualified this may not always be the case. So social worker could be said with lower case or Upper Case spelling depending on who was talking.

Speech language therapist next. This profession has changed enormously. Originally part of a teaching qualification, now a clinical one. Note the name change from Speech Therapist. Also do wonderful work with swallowing difficulties, so need anatomy, physiology, pharmaceutical knowledge.

The Pharmacist was an amazing addition to the team. Again the question what was her training? Hospital or retail? Did she do any postgraduate work? Did she attend any inservice training? Did she know any anatomy? Was she able to manage a Ward setting?

Has changed from apprentice plus technical training to Diploma Course at Polytech

Could have included, and sometimes did, the podiatrist, (previously known as the chiropodist with 6 weeks training, now a CIT graduate). the dentist, chaplain, and where did the family fit .

Now in the era of personal nurse, who was s/he and what level of experience?

Did any of them have professional accountability like the doctor did? What about ACC, the money, support groups.

Health and Disability Commission act 1994

Purpose was to promote the rights of Health consumers and Disability service consumers, and to that end to facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights.

HEALTH Practitioners Competence and Assurance Act 2003

Public act 2003 No 48

Principal purpose was to protect the Health and Safety of members of the public. Looked at registration of most of the health Professionals.

****The extra part of the job description. To make the team work properly all needed goodwill, good interpersonal skills, a genuine respect for the other professions, and an open mind.

For DOCTORS **confidentiality** and **Responsibility** have been key factors in their patient interaction.

The advantages : Shared responsibility

Increased knowledge base

Interprofessional friendships

Disadvantages; who is responsible?

Are we all on the same page?

What about confidentiality?

Who talks to the family?

Blurring of roles, especially for the therapists. Some did a second diploma.

The impact on patient care. Was there one?

Yes, probably. Hard to quantify. Real advantage for the health professionals themselves if they were willing.

Good for families.

Less fragmentation.

Even if you didn't ever work in a multidisciplinary team, the chances are that you will be the patient of one!