Teamworking in palliative care

It has been said that multiprofessional teamworking is a well-developed characteristic of the activity we know as palliative care. There are few other disciplines where the core team includes members from such a diversity of backgrounds, although many include professions in addition to doctors and nurses. Examples include: the rehabilitation professions of physiotherapy, occupational therapy and speech and language therapy in care of the elderly; social work and psychology in care of the elderly, mental health and handicap; therapy and diagnostic radiography in oncology; and laboratory scientists in pathology. However, the medical profession has occasionally been accused of seeking to maintain a stranglehold on most, if not all, clinical specialties. Such rivalry diverts energy from the real challenges and is futile.

I am pleased to note that this issue of the *EJPC* contains articles written by six different professions. While the culture of authorship has often been linked among doctors with career progression and self-advancement, there is now a new imperative in all professions to write, share, publish and 'be damned'. This must be considered as progress from old stereotypes and outmoded boundaries.

Changes in culture can only become received wisdom when they are enshrined in the education and training of the next generation. I am reminded of one UK medical school that obliged all new students to work for two weeks as junior ward nurses (not my own, alas). Those readers of Solzhenitsyn's *Cancer Ward*[1] will remember that the medical student, Zoya, works as a nurse in preparation for her entry into the hierarchical medical profession. Perhaps there was a realisation that medical advice and decision-making was best informed by the experience of patients' daily concerns rather than the doctors' intermittent perceptions.

Multiprofessional education has been demonstrated on many occasions, and palliative care has been a successful model.[2] Naturally, there are drawbacks as well as advantages, although in my experience the latter always outweigh the former.

In the UK, there has been a realisation that early postgraduate medical education could be improved. This has been explored by the Department of Health's *Modernising Medical Careers*,[3] in which junior doctors will be required to undertake a foundation programme after basic qualification. Pilot schemes are now in place using the new curriculum.[4] One of the modules is 'Working with colleagues' in which team-building, inter-professional communication and personality attributes are explored. It soon becomes evident that a diverse group has inherent strength, but that leadership is crucial. Doctors may or may not have adequate leadership qualities, and other professions may make better 'consensus finders' or chairpersons. The good news is that such skills can be acquired, as well as being innately present.

Another development that has been explored is that of nurse and pharmacist prescribing. There are now several examples of palliative care nurse prescribers who are working both independently and in conjunction with medical colleagues as supplementary prescribers. At present, the approved formulary is too restricted to be of maximal use. However, current experience is that such nurse prescribers are at least as well informed as their medical counterparts. Doctors should welcome prescribing colleagues as contributing valuable therapeutic insights to the multiprofessional team, rather than feeling threatened that a hitherto medical activity is being usurped.[5]

However, these are only steps on the way to improving palliative care teamwork. Even the new foundation years curriculum has not included either patients, carers or volunteers in the team. Perhaps this is an insight that we in palliative care have understood for some time and could share with our generalist colleagues.

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