grateful if any doctor, whether in Britain or elsewhere in Europe, who has a patient would write to us at 10 Nichols Green, Ealing, London W5 2QU, so that we can provide details about the register.

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Aggressive patients—what is the answer?

SIR,—Although I sympathise with Dr K Raghu's heartfelt letter (3 November, p 1147) about his difficulties with an aggressive patient and although I cannot simply "come up with a realistic answer to the problem," enough has been written for us now to be aiming to understand these situations. They then need no longer provoke such amazement.

It was pointed out in 1961¹ that when anxieties become too much for the patient or patient group to contain they overflow and outside help is called in. If a major factor of the distress is or can be made to appear to be medical, the general practitioner may be called on as the source of the help. The person who makes the request for a visit (the "intermediary") is responding to his subjective view of the situation—that is to say, to his own anxieties.² It is these anxieties which initiate the doctor's visit and they do not necessarily relate to the medical need. The way in which these anxieties are expressed—that is, the way the request for a visit is made—will set the tone of the visit.

Sometimes, as in Dr Raghu's case, no medical intervention is needed but unless inquiry is made into the intermediary's anxieties the cause of the visit remains unknown and the distress is not relieved. The consequent lack of satisfaction for both the doctor and the patients will be inevitable. In Dr Raghu's case, the intermediary's phoning twice while the doctor was on his way was an indication of the intermediary's agitation, not necessarily of his maliciousness. The need is for the doctor to understand the cause of the agitation and he may then be able to resolve some of the distress. Thus it is important for the doctor consciously to aim at a diagnosis or formulation of the problems of the intermediary. The usefulness of his visit may be seriously reduced if the intermediary is excluded.

If these points are not understood, the doctor is unlikely to find any alternative other than trying to control the "abusive and impudent" caller and wishing to have recourse to his being "disciplined or reprimanded for his behaviour."

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¹ Clyne, M B, *Night Calls—A Study in General Practice*. London, Tavistock Publications, 1961.

² Bailey, A J M, *Journal of the Royal College of General Practitioners*, 1979, 29, 137.

Home monitoring of blood glucose using filter paper strips

SIR,—We have previously reported a method of home monitoring of blood glucose by the collection of capillary blood samples on strips

of filter paper.¹ The method has now been adapted so that the glucose estimation is automated and we report here details of the modified method.

Whatman 4619 filter paper strips are prepared by soaking them in 5% boric acid, to preserve glucose in the dried blood. A drop of capillary blood is applied to the strip to form a blood spot, which is allowed to dry at room temperature. When a series of timed blood samples have been collected the strip is returned to the laboratory wrapped in a polyethylene bag.

Discs of 6 mm diameter are punched from the centre of each blood spot and contain $11 \mu\text{l} \pm 2\%$ dried blood. Glucose is eluted from the disc with 300 μl of 2.5% sulphosalicylic acid for one hour; this also precipitates plasma proteins and haemoglobin in the filter paper disc. After mixing, 30 μl of the eluate is sampled by the autoanalyser and mixed with diluent and colour reagent for glucose estimation by a modified Trinder method.² No protein is present in the eluate so that the dialysis stage of the procedure is bypassed, which increases the sensitivity of the method about 40-fold. At the beginning and end of each batch of 30 samples 1 mmol/l glucose solution standards are run for calibration, with several blood spots of known glucose concentration as control samples. The technical details of the method are reported in greater detail elsewhere.³

Recovery of glucose from dried blood spots is approximately 98% for up to three weeks after preparation for blood samples with a wide range of glucose concentrations. The coefficient of variation of the method between batches is 4%.

The technique of capillary blood collection is demonstrated to each patient as blood spots that are too small, or have not soaked thoroughly into the filter paper, will result in underestimation of the blood glucose. Such samples are identified by preliminary inspection and discarded. Falsely high results are obtained if patients apply more blood to an already dried blood spot. This method of home monitoring of blood glucose has proved cheap and reliable and applicable to large numbers of samples.

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¹ Wakelin, K, et al, *British Medical Journal*, 1978, 2, 468.

² Trinder, P, *Annals of Clinical Biochemistry*, 1969, 6, 24.

³ West, P, Marsland, I G, and Bradshaw, P, *Medical Laboratory Sciences*, in press.

Multidisciplinary teams

SIR,—Drs James Appleyard and J G Maden (17 November, p 1305)—paint a disturbing picture of the ill effects of the multidisciplinary team. Why have such teams arisen, and why is there pressure to displace medical leadership? The multidisciplinary approach has grown up in those specialties where professionals other than doctors have a significant contribution to make. Perhaps the oldest "team" in medicine is the co-operation of ward sisters and nurses with doctors; but few people would call this a "multidisciplinary team." In specialties such as psychiatry, child health, and geriatrics the social worker, the community nurse, and when available the psychologist are further important team members.

To function well a team needs a common aim: the health of the patient or client. It also needs a leader. In most cases the doctor, with

his very broad-based and prolonged training, was originally regarded as the natural leader. Such a leader, while retaining responsibility for his team, may be willing in special circumstances to delegate his leadership to a member of the team more qualified to deal with a particular case. I believe that pressure to displace doctors from leadership roles has arisen from two main sources. Firstly, some doctors are naturally very poor leaders, for reasons varying from an overbearing manner to an inability to take decisions. There is very little attempt at the undergraduate or postgraduate level to train doctors in the skills of leadership. Secondly, other professions have developed management structures which remove authority from those workers directly concerned with patients or clients. The managers in these structures cannot easily be involved in multidisciplinary team decisions about real patients. On the other hand, the social workers who see patients may be very restricted in their ability to make decisions on behalf of their departments. However, managers higher up the hierarchical structure want their professions to have a say in patient care. This seems to be an unresolvable conflict unless other professions are prepared to adopt the medical management structure, with its emphasis on the individual responsibility and authority of the doctor who is in personal contact with the patient.

There is another pressure at work, linked to this but even more disturbing. This is the pressure not just to displace the doctor as team leader but to do away with individual leadership and responsibility altogether. Our bureaucratic society seems to be generating people who are unwilling to be mistaken, and therefore unwilling to make decisions. The committee is the bureaucratic instrument for avoiding responsibility. The individual expert is displaced, authority and risky decisions are avoided, and the Health Service stagnates.

We need multidisciplinary teams, but there must be a leader who accepts responsibility for decisions and has the authority, which should never be divorced from responsibility. If this is ever to be achieved management structures must be changed. If doctors want to be team leaders, they need more than "sapiential authority"; they also need to work at developing real leadership skills and to fight hard against any erosion of individual clinical responsibility.

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SIR,—The points raised by Drs James Appleyard and J G Maden in their article "Multidisciplinary teams" (17 November, p 1305) demonstrate very clearly when applied specifically to child psychiatry the way that children's best interests can be sacrificed on the altar of administrative and financial convenience. For instance, to avoid psychiatric opinions that might be contrary to those of the local education authority (LEA) members of the multidisciplinary team the obvious manoeuvre is for these members not to bring to the team for discussion any cases which might predictably lead to conflict and with it the risk of an authoritative psychiatric or medical opinion that ties their hands and prevents them from carrying out only those "conventional" procedures autocratically advocated by their employers—the LEA and, to a lesser degree, social services department.

The psychiatric member of the multi-