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Management of the team in general practice

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A team is generally considered to be an association of people having the same intent and goal. The goal of the health care team in this setting is to provide the patients and families with the best comprehensive health care possible.

In the early experience of this project it soon became evident that merely putting people together into a group did not necessarily make a 'team' in the functional sense (Beloff and Willet, 1968).

How many general practitioners have discovered this for themselves? The current emphasis on teamwork in general practice and the rapid extension of attachment schemes for local authority nurses have raised problems as well as created new and exciting possibilities for work in the field of primary medical care.

How can teamwork become a reality in general practice? There is no simple answer to this question, but an analysis of some of the problems may provide a basis for further discussion and help to stimulate experiment and systematic evaluation. In this discussion of the management of the team in general practice, I shall draw on personal experience, on the published work of others and on the results of a small study in which a colleague and I investigated the working of seven general-practice teams in a northern English city.

The composition of the team

Although detailed discussion of the composition of the team is outside the scope of this essay, it is difficult to explore problems of management without first briefly considering the question of who should be involved in the general-practice team. It is useful to distinguish between the professional, primary care team, composed of people directly concerned with patient-care, and the secretarial and administrative staff who perform essential supporting functions for the professional workers. As the report of the Sub-committee on the Organisation of Group Practice (1971) pointed out, larger group practices may have a considerable staff of receptionists, secretaries, records clerks and technicians who pose their own management problems. Although many of the principles of teamwork can be applied equally to all groups, the subsequent discussion will be concerned specifically with issues arising from inter-disciplinary teamwork among professional people.

Which professional workers should comprise the primary care team? At present no single answer can be given to this question. Obviously the primary-care team cannot provide all the skills which patients will require—it will at times be necessary to draw on specialist services in both health and social work fields. But the primary-care team should be able to assess the total needs of the patients, and where they are not able to provide the required services themselves, they should ensure that as far as possible the patients' needs are met in a co-ordinated way.

In general, the team should be able to offer to the patients, medical skills of diagnosis and therapy, domiciliary nursing care in acute and chronic illness, as well as knowledge and skills in health education, personal preventive work, and the social and psychological dimensions of health and illness. The problem is that of balancing the advantages of the small team, which avoids undue fragmentation of care, with the need to ensure

that the special skills of each professional person are used to the best advantage and to an extent which enables the worker to maintain competence and keep abreast of modern developments.

Primary health teams will, of course, evolve from existing patterns of service and existing personnel, and for some time to come are likely to consist of general practitioners with home nurses, state enrolled nurses, health visitors and sometimes social workers from the social service departments. Factors influencing the composition of any particular team will include the interests and abilities of available personnel, the number of general practitioners working together, the age and sex distribution of their practice population, and its rural or urban situation, as well as local administrative problems.

The great need now is for flexibility and willingness to experiment. Some teams will provide primary care by one or more general practitioners working with a generalist or community nurse assisted by a state enrolled nurse; others will have a home nurse, a midwife and a health visitor; some will have social workers directly attached, while in others, the health visitor will provide 'first level' social work and consult when necessary with social workers in the social service department. All these models should be tried out and evaluated so that the patterns of the future can be based upon firm foundations of experience and knowledge.

General-practice teamwork—a review of the literature

Assuming that the administrative problems of attachment can be solved, and that nurses and social workers base their work on practice populations of suitable size, how can a team be created from a group of individuals with widely varying backgrounds and experience? Will they really provide comprehensive and co-ordinated care, or will they continue to work as separate professionals serving the same population?

Many papers have been published which describe the work of nurses (Hasler, *et al.*, 1968; Swift and MacDougall, 1964; Dixon and Trounson, 1969; Marsh, 1969; Smith and O'Donovan, 1970) and social workers (Goldberg, *et al.*, 1968; Wolfe and Teed, 1967; Evans, *et al.*, 1969, Dickinson and Harper, 1968; Ratoff and Pearson, 1970; Confino, 1971) in general practice.

Most have spoken of the increased job satisfaction which usually results from better communication and more effective use of skills. A few have suggested that the transition to teamwork may raise problems. Walker and McClure (1969) who studied nurses' view of attachment, showed that the transition from independent work to attachment makes demands on all concerned and suggested that the effort required may have been underestimated. They emphasised the importance of a period of informal attachment, or courtship, before attachment proper and suggested that the ultimate success of any scheme is an individual matter depending upon the personalities and motives of those involved.

The importance of compatible personalities for the success of team working has been generally recognised. In an effort to ensure this, several reports (Warin, 1968; B.M.A. Planning Unit, 1970; Subcommittee on the Organisation of Group Practice, 1971) recommend that doctors and other team workers should be consulted about the selection of new staff when a vacancy occurs. Compatibility of personalities is obviously an important factor which will influence the ability of the team members to work together.

When the selection has been made, the next task is to find a way in which the attributes, experience and training of each worker can be used in a joint endeavour. Consideration of some general principles of teamwork may help in this, but so far

comparatively few attempts have been made to discuss inter-disciplinary professional relationships in the context of general practice.

The report of the Working Party on *Primary Medical Care* initiated by the planning unit of the British Medical Association (1970) recommended that the team should be guided by two principles—first, maximum use must be made of the skills of all team members, and secondly, the team's efforts should be planned and co-ordinated in such a way that there is effective liaison between them and with workers in other sectors of care. The report emphasised the importance of establishing unambiguous methods of reaching decisions and stated that all those working in the unit should have a clear indication of their responsibilities and their rights to participate in the decision making which is likely to affect those responsibilities.

Communication

More recently, the Subcommittee of the Standing Medical Advisory Committee, in its report on the Organisation of Group Practice (1971), pointed out the need for clear lines of communication between the workers, for clear definition of the fields of the various professions and for good relationships so that each understands the other and respects the other's capabilities and potentialities.

The report stresses the importance of joint planning and of regular meetings which would give opportunity for consultation and collaboration, members of the team deciding together which is the most suitable service in a given situation. It concluded that the doctor should remain "the clinical leader of the team" and agreed with the view that there is "a need for some sort of hierarchical structure if group practice is to be stable."

Commenting on this report, the Council of the Royal College of General Practitioners (1972) expressed the opinion that the problem of small group management had been merely touched on and that there is a need for more careful research into management in the context of general practice. While agreeing that the doctor must be responsible in all clinical matters, the Council had reservations about the need for a hierarchical structure.

Status

Crombie (1970) discussed in detail the question of a status hierarchy in the domiciliary health team. He suggested that most teams, whose major concern is with service, will retain stability best if they have clear cut, non-overlapping roles arranged in an apical status hierarchy. In such a team, rapid staff turnover can be accommodated without undue difficulty. Crombie pointed out that while innovation may be encouraged in a team with loosely defined, overlapping roles held together by peer relationships, such relationships take a considerable time to develop, and can readily be upset by staff changes. He also stressed the need for objective data which will relate the type of relationships in the team to its stability and effectiveness in assessment and therapy.

Most of the published work relating to actual experience of teamwork in general practice has concentrated upon describing the roles of individual workers, and has seldom considered in any depth questions of authority, decision making and leadership, or the problems which can result from different attitudes and values amongst team members. Those striving towards effective teamwork are aware of these problems, but rarely are their deliberations made public.

Perhaps our colleagues across the Atlantic are less reticent, for one of the few detailed descriptions of experience in developing a health team comes from the Yale Studies in Family Health Care (Beloff and Willet, 1968). The team consisted of physician, public health nurse and health aid, and they sought to give comprehensive health care to multi-problem families by co-ordinating the efforts of medical and allied personnel. They

experienced difficulties resulting from the traditional relationships between physicians, nurses and social workers. Initially the paramedical personnel were allowed little responsibility for patient-care and had difficulty in establishing a clear identity. Only when adequate communications were established with team conferences and weekly seminars, and when team members learned to be frank and express their thoughts honestly, did relations improve. After two and a half years of working together the team developed into an effectively functioning group where the leadership varied with the nature of the problem being discussed, and the emphasis was centred entirely upon the needs of the patient, rather than upon preconceived ideas of the role or status of team members.

Similar problems were encountered by a doctor–nurse team in Ottawa (Heaton and Flett, 1971). An experienced nurse who was used to making joint decisions began to work with a doctor in solo practice who was used only to giving orders and who thought of the nurse's role as subordinate. Again, regular weekly meetings with honest expression of opinion, flexibility, and a determination to focus on patients' needs, gradually resulted in the growth of an effective partnership.

This brief review of the literature has revealed that discussions of teamwork have some common themes—the need for role definition, the problem of leadership and authority, the importance of adequate communication, and the necessity for agreement regarding goals and priorities. I turn now to consider each of these themes in more detail, in each case describing first the results of a small personal study of general-practice teams, and then discussing the issue in a wider context.

Background of the study

This study was conducted by Mrs H. Mitchell, a sociologist colleague, and me in a northern English city about four years ago. The aim was to explore some aspects of team work in seven general-practice teams. Each team consisted of two or three general practitioners, together with an attached home nurse, a midwife, a health visitor and a social worker from the mental-health division of the local health authority. The attachment was similar to many other schemes in that the work of the local authority staff was based upon the practice population rather than upon geographical areas, but they were unable to spend full time in the practice owing to other commitments for the local authority.

The intention was not merely to initiate attachment schemes, but to create family-doctor health teams in which co-ordination would be encouraged by regular meetings in each practice of the attached workers and the general practitioners. At the time of the study the attachment scheme had been in effect for periods varying between nine months and two years, so that the teams were still exploring ways of working together, and few had established stable patterns of relationships.

The study was exploratory and aimed to investigate problems of role definition, of authority and decision making and patterns of communication within the teams. Each worker was interviewed separately using an interview guide which ensured that certain topics were covered. Throughout the interview spontaneous comment was encouraged and most developed into a free expression of opinion and experience relating to teamworking. Where there had been recent changes of staff we interviewed both workers who had been involved in the team. Forty-seven workers had participated in the seven teams and 46 of these were successfully interviewed. These included 16 doctors, eight health visitors, seven home nurses, six midwives and nine social workers.

Role definition

Method

Role definition was studied in two ways. Each member of the team was asked general open-ended questions about his own function and the function of each of the other team

members. In addition, each worker was given a list of 18 hypothetical cases (Table 1) and asked what they would do if they met such a patient, assuming that no one else was already involved. In particular who did they think was the most appropriate person to deal primarily with such a case?

The hypothetical cases were chosen primarily to investigate the role expectations of the home nurse, the health visitor and the social worker, and the possible overlap between them. It was recognised that the doctor would be involved to some extent in most of the cases. An extended range of problems would be required in order to focus on the role expectations of the doctor or the midwife.

TABLE 1

HYPOTHETICAL CASES USED IN THE INVESTIGATION OF ROLE EXPECTATIONS

1. Young mother of a baby of six months refusing to go on solid food.
2. Mother of a girl of ten years who wets her bed nearly every night.
3. Boy of 15 with a boil on the neck.
4. Woman of 50 with a heavy cold, temperature and running nose.
5. Mother of a boy of 12 who refuses to go to school when there seems to be nothing wrong with him.
6. Middle-aged woman, recently widowed, who has lost all interest in life.
7. Parents of a boy of 13 who persists in stealing small things.
8. A mother whose only child of 18 months has just been found to be mentally subnormal.
9. A married woman of 35 who has just returned home from a mental hospital and needs help to try to adjust to family and social life.
10. A married couple who quarrel so much they are beginning to think seriously of divorce.
11. Woman patient of 75 with long standing osteoarthritis, living alone, and becoming unable to manage housework.
12. Couple of 25 who want advice on family planning.
13. Man of 45 just returned from hospital after losing a leg in a road accident and needs help to re-adjust himself to life.
14. Wife of married man of 70 whose deafness, in spite of his hearing aid, has made him withdraw from his normal social activities.
15. Parents of a 'teenager who have just found out he is taking drugs.
16. Wife of a man who appears to be habitually drinking too much.
17. Mother of a young family who is living in a rented house, the roof of which is leaking.
18. The parents of a girl of 16 who has just left school and started work in a factory. She hardly talks at all and has no friends and never goes out.

Results

In general the workers saw themselves to be concerned with a wider variety of cases than the other team members attributed to them. For example, the health visitors said that on average 11·4 of the 18 cases would be primarily within their scope, whereas the doctors saw the health visitors involved with an average of 5·9 of the cases, the midwives and home nurses saw the health visitor involved with an average of 5·1 of the cases, and the social workers 'gave' the health visitor an average of three cases.

Analysis of the perceived content of the health visitors' work showed that there was almost unanimous agreement that she would be the team member primarily concerned with the feeding problems of the baby (case 1) and with social problems resulting from disability of the elderly (case 11). She was not seen by anyone as involved in curative work (cases 3, 4). Nearly all the health visitors said they would be concerned with behavioural problems of childhood and adolescence (cases 5, 7, 18) and about half saw a role for themselves in the after-care of the mentally ill (case 9) and in helping with problems of potential drug addiction (case 15) and alcoholism (case 16).

On the other hand, only one third of the doctors and other nurses saw any place for the health visitor in these cases, and none of the social workers envisaged the role of the health visitor to include behavioural and mental problems. Problems of marital disharmony (case 10) and reaction to bereavement (case 6) were seen as within the scope

of the health visitors by most of the health visitors themselves, but by none of the social workers and by less than half of the doctors and other nurses. The health visitors and social workers, however, agreed that the health visitor should be concerned with patients requiring family planning advice (case 12) whereas very few of the doctors or other nurses saw this as within her role.

This part of the study not only revealed marked discrepancies between different members' perception of the role of the health visitor, but also a considerable degree of overlap in the perceived roles of the various workers. In some cases, such as the reaction to bereavement (case 6) the home nurses, health visitors and social workers all saw themselves as primarily involved, and several other cases were claimed by both the health visitors and the social workers as mainly their responsibility. Despite this evidence of overlapping roles, there appeared to be very little conflict, and the need for flexibility was stressed many times.

Few of the workers felt any need to defend their own area of competence, and they did not appear to be distressed when others were evidently doing what they regarded as 'their' work. Often the comment was made that the right person to deal with a particular situation would be the worker who knew the family. As one social worker said "the person who has an established relationship with the patient is the best person to carry on." Some of the social workers were glad for the health visitor to work with families who had social problems, so long as she was prepared to consult them when further help or advice was required.

Discussion

Many other studies have recognised the potential overlap between the work of members of the health team, especially between the home nurse and the health visitor (Walker and McClure, 1969; Boddy, 1969) and between the health visitor and the social worker (Jefferys, 1965; Forman and Fairbairn, 1968). Forman and Fairbairn estimated that 27·5 per cent of all matters referred to their medical social worker could have been managed entirely by the health visitor and 35·6 per cent dealt with partially by her.

At a recent meeting held at the Royal College of General Practitioners (1971) it was pointed out that doctors were using health visitors and social workers in the same way on the same problems, and that often when the health visitor was more easily available, or was attached first, she might be doing a large proportion of work more appropriate for a social worker. This was certainly the case in the teams we studied, especially in one team where the health visitor was attached first and had established a firm place for herself before the social worker joined the team.

Some reports (Subcommittee on the Organisation of Group Practice, 1971) have stressed the importance of clear role definition. Why is this necessary? It seems that in the initial stages of teamwork, when workers are unsure of each others' capabilities and expectations, many feel a need to clarify what they see as their particular functions. They hope in this way to prevent 'abuse' and to ensure that their special skills are recognised and used to good advantage.

It is interesting to read that in the early stages of the Yale Health Care Team (Beloff and Willett, 1968) the various members of the team prepared written descriptions of their potential roles. These were circulated, discussed and then " filed away in a folder and little used". They also spent a lot of time discussing role definition and philosophy, but report that it was team action in real life situations which determined the true shape of each person's contribution to the team.

I suspect that this sequence of events may be a common pattern in the growth of general-practice teams. The stage of definition of roles and discussion of functions is necessary, but as the team works together on specific cases over a period of time, they

come to appreciate each other's skills and capabilities and to realise where and when it is appropriate to involve another professional worker.

There is one other aspect of role definition which should not be overlooked. This is the potential conflict which may result from varied expectations of the general practitioners and the professional nursing and social work supervisors in the local authority. It is important that there should be broad agreement about certain limits in order to avoid conflicting pressures on the nurses and social workers involved in attachment schemes. For example, the nursing supervisor and doctors should agree about the extent of the home nurses' duties in the surgery, and whether she should be expected to do first or follow-up visits on behalf of the doctor.

In most cases it appears that the nurses' fears that general practitioners would expect them to undertake clerical duties have proved to be entirely unfounded, but such issues should be clarified before attachment so that the nurses are not faced with problems arising from divided loyalties. Once agreement has been reached on the main issues, most nurses are only too willing to be flexible and meet the needs of particular situations which arise. It should also be pointed out that although the broad outline of the role is laid down at first, it is always possible to leave room for changes and expansion as opportunities for experiment arise.

Leadership

Method and results

In investigating leadership, authority and decision making in the seven teams, we tried to find out the extent to which the doctor was seen to be in a position of leadership. We asked each worker, including the doctors, how they regarded the position of the doctor in the team and how a conflict of opinions about the best course of action for any particular patient or family would be solved.

Half the doctors described themselves as the leader of the team, the director, the person whose job it was to take control or responsibility. A similar number said that if a conflict of opinion arose, after discussion with the team, the doctor would decide which course of action should be taken. On the other hand, five of the 16 doctors saw themselves as co-ordinators in the team, and two specifically denied a leadership role. In their teams all matters would be decided by mutual discussion.

The great majority of the home nurses and midwives unhesitatingly described the doctor as the leader of the team, and about half of them said that the doctor would decide what was best for any patient. The remainder of the home nurses and midwives favoured mutual discussion for decision making.

Many of the health visitors followed the other nurses in regarding the doctor as leader or head of the team, but three (out of eight) placed special emphasis on the need for a colleague relationship which would destroy the idea of the nurse as 'handmaid to the doctor'. In case of disagreement about a course of action, these health visitors felt that their opinion was of equal value with that of the doctor and as one of them said "I would argue my point if I thought the patient would benefit."

The importance of shared responsibility for decision making was put even more strongly by the social workers. A majority of them described the doctor as co-ordinator or central figure, rather than leader or head, and although usually conflicts would be solved by discussion, on occasion a social worker would feel strongly enough to call for the help of the social work supervisor to "fight for what I believe in."

Thus there appeared to be a gradation of views regarding the leadership of the doctor in the team. The home nurses and midwives, whose work has long been associated with that of general practitioners, tended to adopt the traditional nursing view of the doctor as the head of the team. The social workers, at the other extreme, were very conscious

of their professional skills as complementary to those of the doctor, and, although they recognised the central position of the general practitioner, they did not think that his judgment should prevail in all cases, particularly those involving social problems. The health visitors held an intermediate position—from their nursing background they retained some acceptance of the leadership of the doctor, but they also saw themselves as having additional skills and insights which general practitioners did not always possess.

We attempted to probe the extent to which members of the team felt able to act on their own initiative by asking each worker whether, in a case where they felt a referral was required, they would call in the help of another worker in the team or a person outside the team without prior consultation with the doctor. There was agreement amongst almost all workers that referrals would be made freely within the team, but that the doctor would be consulted before calling in the help of any person or agency outside the team. This situation met with the approval of a majority of the general practitioners, although a few doctors insisted that all referrals, even those between team members, should come through them. At the other extreme, one or two doctors were willing for any referral, even those outside the team, to be made without their prior knowledge.

Discussion

The question of leadership and authority in general-practice teams is a difficult one, and different teams will come to different solutions, depending to a large extent upon the personalities of the workers involved. It may be that one type of status relationship is not 'better' than another, and that teams organised in different ways will prove to be equally effective. It is probably more important that all the members of any one team agree about the leadership, rather than that all teams adopt the same pattern.

Certainly there are real differences of opinion amongst doctors about this. Reedy (1968) sees the general practitioner as managing director, and Crombie (1969) believes that "there will have to be a boss if an effective team needs to be constituted where its members do not remain together for many years." Evans *et al.* (1969) points out that if the doctor is to be the leader of the team "he should qualify by his talents for leadership rather than by his possession of a medical degree."

There is no doubt that many doctors feel strongly that they should be in a leadership role because of legal responsibility to their patients. But does the acceptance of clinical responsibility necessarily carry with it the leadership of all aspects of teamwork?

Despite the fact that most nurses look to the doctor as leader or head of the team, they also point out that in the assessment of the nursing needs of the patient and in the provision of nursing care, the judgment and skills of the nurse are paramount. Equally, many health visitors are better informed than many general practitioners about health education, preventive work and the availability of social services, and most trained social workers have a considerably greater knowledge of behavioural sciences than most doctors. In so far as professional workers in the team have special knowledge and skills, they expect to be regarded as colleagues and to participate in decision making.

Some will argue that the inclusion of psychology and sociology in the undergraduate medical curriculum and the study of 'human behaviour' and 'medicine and society' during postgraduate training for general practice will ensure that future general practitioners have adequate knowledge of these subjects. But it will not be possible to cover more than the basic concepts of behavioural sciences related to medicine during the time available unless there is either considerable extension of the period of academic training for general practice, or sacrifice of experience in some other areas.

There is a large and growing body of knowledge about cultural and social influences in the aetiology and perception of illness, about factors influencing patients' behaviour, and about the social and psychological effects of illness. Modern health education is

concerned with problems of changing human behaviour and is based upon knowledge of human motivation, decision making and social influences on attitudes and behaviour as well as the techniques of communication. Can the general practitioner acquire expertise in all these areas as well as maintain and develop a broad field of clinical competence? These are subjects which will form the basis for the training of nurses and social workers who will participate in general-practice teams.

Some university trained nurses already have a considerable depth of understanding of the relevance of psychology and sociology to problems of health and illness and they can make a valuable contribution in general practice. But they will expect to join teams in which their professional status is acknowledged by a sharing of responsibility and participation in decision making.

This is looking into the future. Many teams will continue to function with a doctor as the undisputed head of a hierarchical status structure. With increasing professionalisation of nursing and social work, it is likely that there will be a movement towards teams in which, as in the Yale Family Health Care team, leadership varies with the nature of the problem.

In such a team the general practitioner will retain his central position, for it is he whom patients have chosen as their doctor, and he to whom they normally turn first for help and advice. He will maintain and practise his clinical skills, using his knowledge of human behaviour to increase his awareness of the total needs of the patient and his family, and to ensure that as far as possible these needs are met in a co-ordinated manner on a continuing basis by persons with the appropriate skills.

Communication

Method and results

All except one of the seven teams which we studied held meetings, although these varied considerably in frequency and in degree of formality. We attended meetings of some of the teams. Several had informal gatherings after the end of the morning surgery at which team members would discuss current problems over a cup of coffee. One practice held meetings which were formal to the extent of having a secretary who recorded minutes. After an initial period of trial and error most teams found that a weekly or fortnightly meeting was adequate, although informal conversations between individual workers were more frequent.

During the interview each member of the team was asked what they saw as the chief purpose of team meetings, and whether they found them valuable. Most commonly the meetings were seen as an opportunity to discuss cases and pool information about families with whom several of the workers were involved. "We each have a piece of the jigsaw and we fit together the whole picture." At the meetings the help of other team members could be enlisted and a decision made about who should deal primarily with any case.

A few of the workers recognised the value of the meeting in promoting understanding between the different workers and used the opportunity to establish their roles in the eyes of others. Those who saw least value in the meetings were those whose roles were relatively clearly defined, such as the home nurses and midwives. They were often dealing with a small number of patients at any one time, and unless their particular patients were being discussed, they sometimes resented having to interrupt a busy day's work to sit through discussion of families whom they did not know.

Although a majority of workers valued the meetings, a few expressed a preference for individual consultations about their own patients, supplemented by occasional case conferences to which all those involved in a particularly difficult case could contribute.

Discussion

Good communication is widely recognised as an essential feature of teamwork. Both verbal and written communications are important. Law (1970) studied methods of communication in ten large practices all of which had attached home nurses or health visitors. Three of these groups met each morning for clinical conference and five others had clinical discussions once or twice weekly. Walker and McClure (1969) studied nurses' views of attachment schemes and found that although most met with the general practitioner weekly, and some daily, in 20 per cent of the attachments no conferences were ever held.

Team meetings can provide an opportunity for consultation and sharing of information about patients and families. Systematic plans can be formulated for the management of cases so that co-ordination is improved and duplication of effort is avoided. Through the discussions, team members come to understand better the attitude, values and capabilities of each other. Team meetings can also form a basis for occasional extended case conferences to which representatives of outside medical, social and welfare agencies can be invited.

Team meetings do not reduce the importance of developing a unified records system in which each professional worker contributes to a single patient's record card. There are obvious administrative difficulties in this, but provided that the team has adequate secretarial help and makes full use of modern recording and copying equipment, it should be possible to satisfy the recording requirements of both the general practice and the local authority without excessive time being spent on clerical work.

It is surprising that the problem of confidentiality is not raised more frequently in discussions of general-practice teamwork. Perhaps this is because the involvement of several professions in hospital care has long been accepted, so that the transition to similar methods of working in the community is readily made. Despite this, as more and more people have access to records and are present at clinical meetings and case conferences, every effort must be made to ensure confidentiality of personal information. It may be that this aspect of teamwork worries patients more often than they admit.

Goals and priorities

Discussion

The dominant characteristic of a team is that all members have a common purpose or goal. Can we assume that the different professionals involved in general-practice teamwork are united in an agreed goal? It is easy to say that all are striving for the welfare of the patients, yet this broad aim may cover real differences of emphasis and priorities. Our interview did not include direct questions on this point, but some spontaneous comments led us to think that this topic would merit further discussion and evaluation.

It is probably still true that a majority of doctors see their prime function to be the diagnosis and treatment of illness, and the relief of suffering. Despite much talk about the importance of prevention, the personal satisfaction of most doctors comes from being able to treat sick people, and inevitably they spend most of their time doing this. Health visitors, on the other hand, have undertaken special training which has emphasised the importance of health education and prevention and they have chosen to give time to this, rather than to curative nursing. Health visitors often feel that their work is undervalued by doctors who appear to respect more the nurse who 'rolls up her sleeves' to give an injection or attends to the needs of a bedfast patient. The health visitors in many teams feel that they have to educate the other workers about the value of prevention and health education. This may not be an easy task in a situation where the needs of sick people dominate the daily work and discussion.

Social workers are faced with an even greater divergence between their background and training and that of the doctors and nurses. Sometimes there is reluctance on the part of doctors to accept them as colleagues in the team. Despite the fact that general practitioners recognise the existence of social problems in their patients (Jefferys, 1965) a recent survey of practices in a London borough (Harwin *et al.*, 1970) revealed that a majority of doctors did not see a need for regular contact with any social agency. They were opposed to teamwork and only about 15 per cent of those questioned showed an active interest in the attachment of social workers.

The reasons for this reluctance have been analysed in the Seebohm report (1968) and in subsequent discussion (Royal College of General Practitioners 1971). Some stem from doctors' ignorance of the academic background, training and skills of social workers, but there may also be some fundamental differences of approach. For example, most doctors are used to acting in an authoritative manner when giving direct advice on clinical matters. Social workers are trained to adopt a permissive approach, encouraging clients to decide for themselves, while helping them towards an understanding of their own situation.

Doctors tend to value action, whereas much of the social workers' time is spent in listening, and to a lesser extent, in talking. Some of the social workers whom we interviewed felt that the general practitioners were unrealistic in their expectations, demanding solutions to long-term social and personality problems while being able to accept some medical conditions as chronic and incurable.

These differences of approach can create problems for social workers endeavouring to work with general practitioners and some experience this as a stressful situation. It is probably significant that when we questioned workers in the family-doctor health teams about their continued association with the local authority, the social workers were far more adamant than the health visitors about the value of maintaining close contact with their professional colleagues in the local authority.

There are no easy answers to these problems. Increased understanding will come from better training of general practitioners and more association with social workers who are able to express clearly and confidently the concepts underlying their work, and its limitations. As in Derby (Cooper, 1971) general practitioners will be "converted to the idea of medico-social teamwork by example rather than by precept", and attachment schemes for social workers should grow gradually rather than be forced by administrative action.

Despite differences of approach and emphasis, the future for teamwork in general practice will be bright so long as all participants focus primarily on the needs of the patient. Internal relationships within the team are important, but they will fall into place when the patient and his family take first place in the minds of all the workers.

Evaluation

Behind all this discussion and speculation lies an urgent need for experiment and evaluation. There is at present no evidence to help us to decide which is the best composition of the team, or the most effective organisation of relationships with the team. We should compare large teams with small teams: and teams having a formal structure of clearly defined roles and hierarchical status structure with teams having loosely defined roles and a colleague relationship.

The great problem is how to measure effectiveness. By what criteria are we to judge the success of any form of organisation of primary medical care? Reports of attachment schemes frequently mention increased job satisfaction for members of the team, but there is little objective evidence that the quality of care is improved or that patients prefer one

type of practice to another. There is an urgent need for such evidence on which plans for the future can be based. How shall we get it?

Let us start from the patients' point of view. It is of little value to ask patients directly which type of care they prefer or whether they are satisfied with their present form of service. All studies (Cartwright, 1967; Chancellor *et al.*, 1971; Greenhill, 1972) show that when questioned directly the vast majority of people say they are satisfied with the form of care they are receiving. Few are able to envisage advantages or disadvantages of other systems. Freidson (1961) attempted a more detailed study of *Patients' views of medical practice* and concluded that patients judge primary care by three criteria—accessibility, technical competence and personal interest. These may be useful criteria by which the success of teamwork can be measured.

Accessibility

One important characteristic of primary care is that help and advice should be readily accessible to patients. When judging the success of a team it should be possible to measure the ease or difficulty which patients experience in getting the help they need—whether this is medical advice, nursing care or help in a social or domestic crisis—when they need it. A single team cannot be on duty at all times, but where teams work together in larger groups it should be possible to arrange off-duty cover between professionals in different teams so that someone with the appropriate skill is available at all times.

There is one other aspect of the question of accessibility—the danger that within the growth of the team, the doctor may appear to have retreated behind receptionists or nurses. Most experiments in which nurses are doing first visits and screening patients in the surgery show (Smith and O'Donovan, 1970; Smith and Mottram, 1967; Lees and Anderson, 1971) that patients accept this. There are advantages to the patient if the doctor reserves his skills for problems requiring medical assessment and so is able to give more attention to each one. At the same time, reduced ease of direct access may mean that the doctor becomes a more remote and less accessible figure.

Technical competence

The question of technical competence is one which patients are not qualified to judge. Here we must look to the profession to devise criteria by which the quality of primary care can be assessed. This is a difficult but not impossible problem. Work has started on the development of 'norms' for general practice. These are generally accepted standards of management of particular conditions against which the actual activities of any practice can be measured.

It is important that these standards should be realistic ones for the general-practice situation, and not merely transposed from consultants' outpatients' departments. The onus is on general practitioners to state what is good patient-management in any situation.

Where these standards are to be used in the context of a primary care team they should include full consideration of nursing and social aspects as well as medical requirements. The development of such norms will not be an easy task, but until this has been accomplished there will be little possibility of obtaining objective evidence about the success of any form of management of the team in general practice.

Personal care

Finally, any criteria of success must include consideration of the important question of personal care. Is there a danger that the team may destroy the personal doctor? Is it true, as one doctor remarked at a recent conference, that "we must develop the cult of the team rather than the cult of the personal doctor?" Are the two incompatible?

Behind the reluctance of many doctors to welcome the attachment of social workers may be the feeling that they will be expected to hand over the personal aspects of care. They feel with Dubos (1965) that "the danger . . . is that the medical profession may be progressively edged out of many social aspects of medicine".

This is a real problem which deserves closer study than it has yet received. Ann Cartwright (1967) developed some criteria of personal care, and compared patients of doctors working on their own with patients whose doctors were in a group or partnership. She showed that there was no difference between the two groups of patients in the percentage who felt their relationship was friendly or businesslike, no difference in the percentage who thought their doctor was good about listening and explaining things freely to them, and no difference in the percentage who thought they might consult him about a personal problem. The percentage who thought their doctor would know their name if he met them in the street declined from 76 per cent with single-handed doctors to 60 per cent of those whose doctor worked with four or more others.

At the time of this study few practices had evolved multi-disciplinary teamwork, so we still do not know what effect the introduction of paramedical workers has on patients' perception of personal care.

The one study which has investigated this is somewhat reassuring. This was (Freidson, 1961) who conducted a prepayment insurance plan in New York, which compared patients' views of three types of medical practice. Freidson compared patients' assessment of care given by single-handed doctors, by a hospital-based group practice, and by an experimental team composed of internist, paediatrician, public health nurse and social worker. The families concerned in the experimental "Family Health Maintenance Demonstration" had previous experience of solo general practice and of the hospital-based group.

Freidson found that whereas they rated the solo practitioner highly in providing personal care, and the hospital-based group highly in technical competence, the care provided by the team satisfied both these criteria. When interviewed, many patients spoke appreciatively of the interest and personal concern shown by the team, and of the fact that the workers were willing to spend time talking and answering questions.

Hopeful as these findings may be, the situation of this experiment is hardly typical of general-practice teamwork under the National Health Service, and much more investigation will be required before the question of personal care in the team can be satisfactorily answered.

Fox (1960) defined the essential characteristics of the personal doctor as one who looks after "people as people and not as problems". If the doctor retains his central position in the team as the one who is aware of the total needs of the patient and as the co-ordinator who ensures that these needs are met on a continuing basis, there is no inherent reason why he should cease to be a personal doctor.

With greater information and skills contributed by nurses and social workers, and more time to devote to individual patients' needs, he may indeed be in a better position to provide personal care. This is speculation—only careful experiment and evaluation will show whether teamwork and the personal doctor can grow together.

Conclusion

At present we do not know which is the best way to organise teamwork in general practice. Each team will struggle with problems of role definition, of leadership, of communication and of goals and priorities. Different forms of organisation will emerge, and several of these may prove to be equally effective ways of providing primary care. Many questions will remain unanswered until we evolve valid measurements of quality of patient care which are applicable to general practice.

The ideal towards which we strive is a system of comprehensive, co-ordinated care which combines the highest professional standards with a real concern for patients as people. Much has been written about the ideal. Now we need more facts in this, as in other fields of human endeavour.

". . . He who sees only ideals accomplishes little . . . he who sees facts even less. He who grasps both facts and ideals and moulds the actual to the form of a vision is the man who helps to build a better world " (Winslow, 1965).

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