Working together in a team for primary health care—a guide to dangerous country

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THERE is much use of the word co-operation: apparently working together in a team is desirable for many people. On the other hand, it is often unclear whether to give priority to ' together ' or to ' working '. What to expect from co-operation is often just as unclear and the same goes for the amount of effort people are prepared to make and how much has to be left undone.

It is known that working together is difficult, but it is less well established that true co-operation does not come by itself, once people work in the same building, or when they express their wish for co-operation.

This paper describes the evolution of co-operation in the multidisciplinary primary health care team which has been working for five years in the Ommoord community, a new developmental area of Rotterdam.

Other authors in Holland have recently reviewed the same subject. Hollander, Van Ravenzwaay, and Whitlau (1973) contributed to more specific knowledge of problems arising in group practices of general practitioners and group processes in general. Blom and van Es (1972) described the co-operation disaster which took place in Overvecht (Utrecht), an area like Ommoord, where a group practice experiment died soon after birth. This paper contains a report of how we went down the long road to co-operation and the creation of a team.

Stereotype role perception—no co-operation

Before the wish for co-operation with other workers in the field of primary health care a situation exists represented in figure 1, admittedly with a touch of caricature. The four disciplines of health workers—general practitioners, nurses (in Holland these are nurses who staff the well-baby clinics and are the equivalent of the health visitors, but also care for ill people at home), physiotherapists, and social workers are represented by circles. The midwife should also be there, but until now her position in co-operation is different from the other four.

In figure 1 the circles are not of the same size and they do not touch each other. No co-operation exists; on the contrary, there is stereotyped role perception and a false picture of mutual professional abilities. Clearly the general practitioner is the largest circle. His workload is " almost unbearable ", he doesn't have time for anything and it is difficult for the other workers to approach him. He practises somatic medicine at a modest level of cottage industry.

The social worker has only a small circle, almost invisible, exerting obscure activities concerning the poor, and removing the old and unwanted from the community. The nurse is linked to the image of a spinster who goes around cleaning bottoms wearing the clothing of a motorcyclist. Finally the physiotherapist is a masseur, some kind of servant who makes a living by letting his treatment go on forever until the insurance company's refusal to pay any more puts an end to it.

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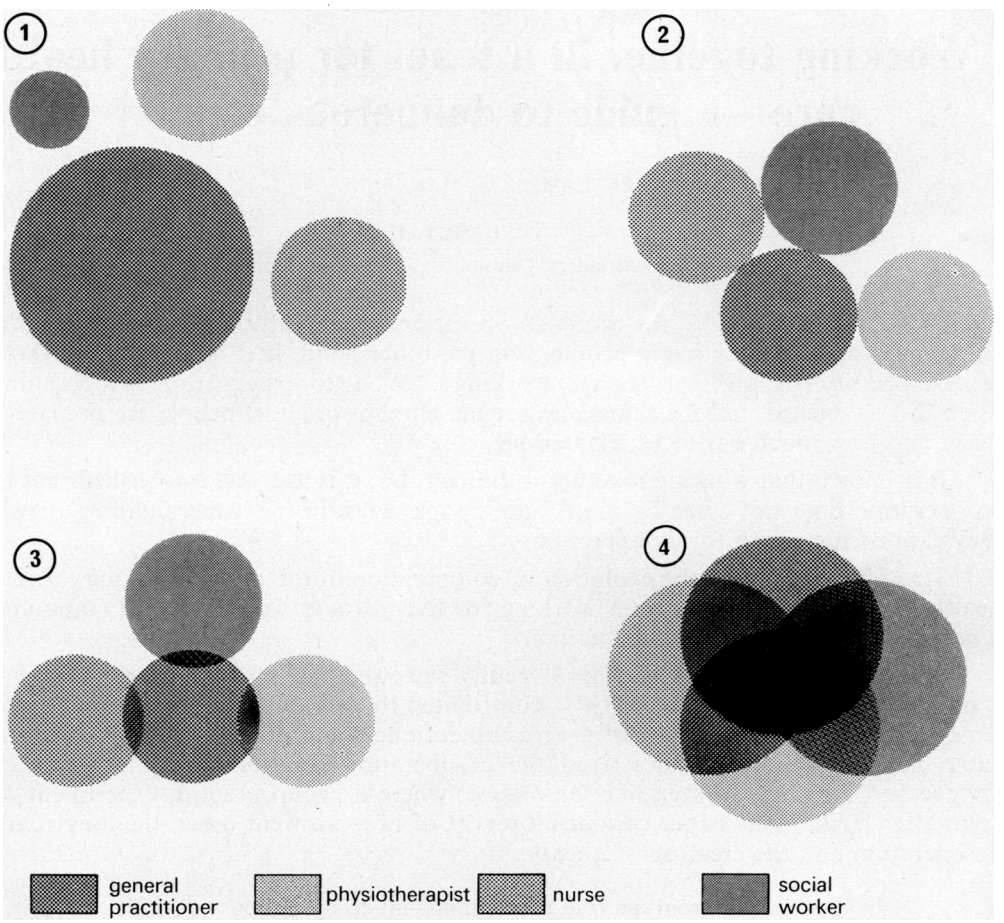

Figure 1
Stereotyped role perception.

Figure 2
More acceptable proportions, still no co-operation
(a) Establishing common shares in everyday work.
(b) Recognition of each other's professional skills.

Figure 3
Relationships in the team, co-operation, looking for common goals
(a) General practitioners providing patients for each of the other disciplines.
(b) Still hierarchical relations within the team.

Figure 4
Relationships in the team, choosing ideal common goal: helping people with existential or psychosocial problems
(a) Every discipline covering the team's common goal.
(b) Retention of a small part of professional privacy.
(c) A complex relationship with many hazards, such as usurpation.

Giving the right proportion to role perceptions

First of all, realistic proportions must be given to the members' ideas about each other's professional role, the circles must be remodelled to similar size, prejudices must be discussed and much information is needed about the daily work of the four disciplines, as well as clear definition of professional abilities and limitations.

Consequently the circles get closer together and touch each other occasionally, but not yet permanently (figure 2). This stage was difficult at first in Ommoord because of our zeal to reach co-operation. Too much was taken for granted, too many traditional and wrong ideas were left. However, this stage is important, because the way things are in Holland, it could well be the ultimate goal to be reached by most health care workers for some time. After this landmark things get harder and co-operation has to be built stone by stone.

Co-operation at last

Figure 3 shows the level of co-operation that was—and still partly is—most important for the Ommoord team. Right in the middle sits the general practitioner, but he allows the other workers on his territory on a small scale and the other circles gradually begin to share small parts. Patients are referred to the others by the doctor, who assumes the role of supplier; he discusses cases with them and keeps an eye on the courses of action the other parties (case conferences and follow up). Communication between the four field workers is essentially one way traffic and always passes through the general practitioner.

This organisation is hierarchical, though this is loudly denied by everybody concerned. This phase may continue for a long time and in Ommoord it lasted for almost four years.

However, sooner or later the circle is broken (figure 5). Now we can see that the whole team was built around the group practice of doctors who sat in the centre of the spider's web, controlling all communication. Some members of the team, in this case especially the social workers and some of the nurses, decided that they would no longer swallow this situation. Not only did they want to leave their " slavery ", but also the doctors began to complain about the inactivity and lack of initiative and motivation of the rest of the team, which seems a rather incongruent reproach when made to a " slave ". So, the other workers in the team felt that the doctors were blocking the efforts they were making towards more professional responsibilities and a more respected image by the team and by the patient or client, whom they didn't want to consider any longer as borrowed property.

On both sides feelings were ambivalent; the general practitioners would like to get rid of their daily burden of hardship and responsibility, but on the other hand the freedom struggle of the other disciplines made them insecure. The other parties were not free of contradictory feelings either: gaining independence and getting a bigger part in decision-making is fine, but life was definitely easier the old way when difficult problems were left to the doctors, who could even be blamed for solving them all alone afterwards.

There were two possible solutions: either the team, which proved not to be a real team, returns to the relationships shown in figure 2, with the circles floating apart, or an effort is made to improve relations and create new relationships. Relational problems have become important and difficult to solve.

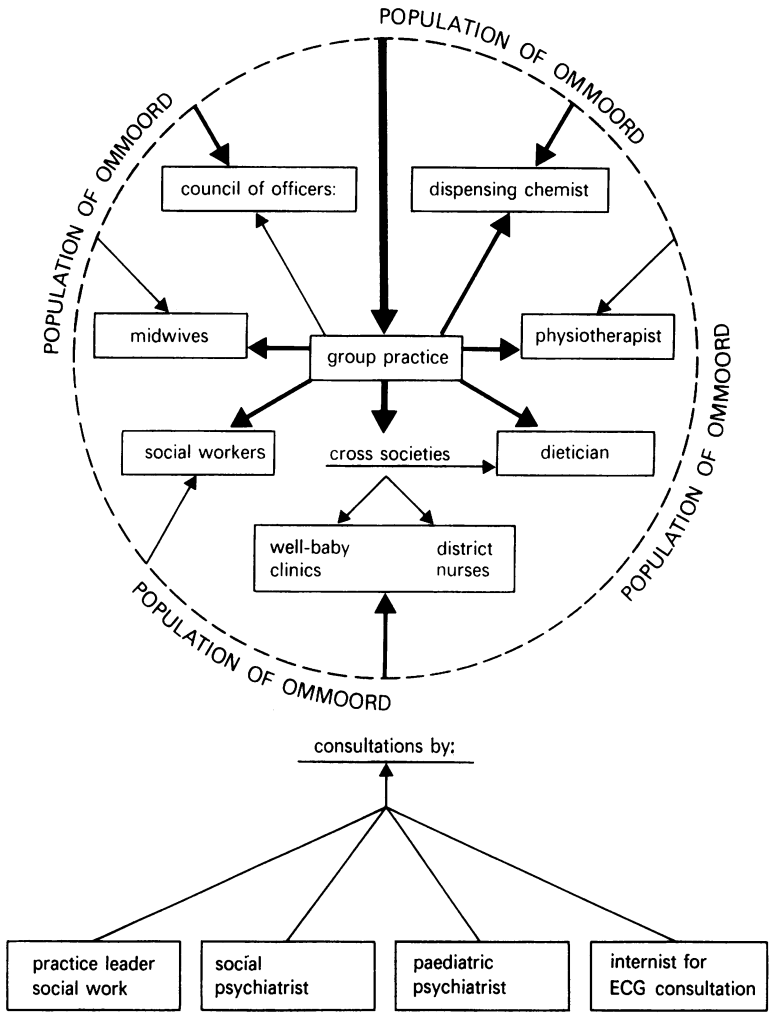

Figure 5
Diagrammatic representation of the team and the group practice.

The common goal

Ideal utopian relationships are shown in figure 4. Four circles cover each other in such a way that each circle has five distinct parts, of which three parts represent close co-operation with the other three disciplines. The size of these parts can of course differ and so do the common parts of the circles. There is a small area of common working ground and its existence can give rise to tensions between workers all the time. Usurpation is at large; not to know exactly your own specific task, doubts about somebody else being better equipped, doubts about the patient's or client's acceptance of a new role—all these are constant threads. Two parts of the circles remain and they can offer some defence against this.

All members of the team share the central part of the circle representing our ideal and official goal, which we hold to be:

(a) A multidisciplinary approach to disease, health, and psychosocial problems in the family.

(b) A multidisciplinary approach to any necessary social action in the Ommoord community.

Some members of our team were not to be entirely loyal to the common goal. People working in a team can sometimes consider the goal itself threatening to their status and relationships with other members, because they are dominated and overborne by the high ideal.

The last remaining part of the circle is shared with no one else in the team and represents the link with the old, trusted, and relatively safe professional background. There are in principle three types of role conflict to which any team member can be exposed: those within one's own professional group, those within the team, and those within the relationship with the client. As a reaction, the team decided to reduce the number of disciplines to those which really played an active part in everyday life and to alter relationships to a more horizontal level. This is the reason why—from the point of view of health care—the central or nuclear team (figure 6) was separated from the " rest " of professional help-giving people in Ommoord (the dietician, pharmacist, policeman, social security doctor, community, and educational workers, priests and the staff of old people's homes, although all these are vital to community development and have many working contacts with us.

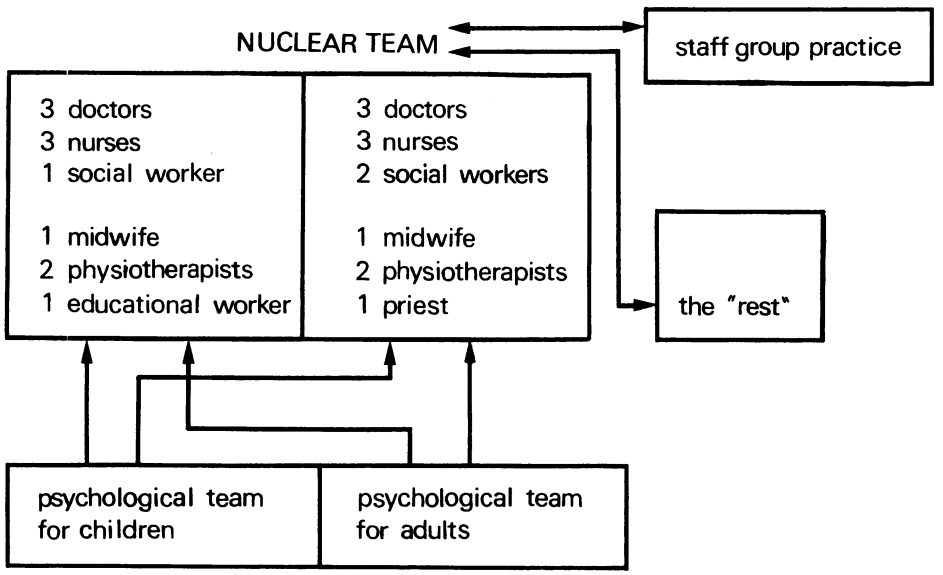

Figure 6
The composition of the nuclear team and its relationship outside the practice.

The central team also has official working relationships with two different teams, consisting of members of the local authorities, psychiatric staff, an adult and a youth team who work in the same building. This relation is, however, not very close.

All members of the central team work in the health centre (with the exception of the priest and the community-development worker) and have the same privileges; they are all supposed to be present at 10.45 for coffee. Twenty-two is too large a number for more intensive or complicated activities, so the central team is divided into two equal subteams, which hold joint case discussions every two weeks.

These subteams also went through a course of " relationship training ". Much has changed and the ideal situation of figure 4 seems to have been realised, at least partly. This picture is misleading for two reasons: many interpersonal relations in the team

still have to be improved and every new situation is unstable; development threatens stability.

Forming new groups

Important changes dominated the last five years for every discipline of workers, doctors, nurses, and social workers alike. Many of the original team of 1968 have left and the number of workers in every discipline has been doubled. The original members were gaining experience, learning new techniques, coping with personal problems, and doing research and as they did this they felt the need for new common goals and improved relations with the team.

New members joined from time to time and brought new ideals and expectations of teamwork. The new felt much was being asked of them and that they had to be tough and progressive. Keeping in line with the rest of the team they soon discovered mixed feelings, including warm feelings, between members, by which they were somewhat confused, and they had no clear picture of exactly what was required of a new member.

A new ideal team is conceived on such occasions, and a new search begins for goals and the possibilities of pleasant co-operation. This movement to a new relationship for the whole team was clearly seen as a reaction to the following events: the arrival of three new nurses of modern professional style, two women doctors, and two young social workers, the move to the new building with an ' open day ' to open it officially, and financial problems for the general practitioners.

Every time a new member joins, the team has to give and take, re-group cohesively and then begin to work towards the goal. The stage of give and take and getting acquainted is partly covered by figure 2: circles of proportionate size and floating in each other's direction. Birth of a new group feeling and co-operation are represented in figure 3 by the circles partly covering each other. Finally a steady state is reached (though often only for a short time) and everyone works in the same direction (figure 4).

More complications—the personal problems

All this sounds complicated and tiresome, and in fact is, because problems of personal relations get in the way, time after time. The nature of this process is complicated because the intermingling action between the various subgroups and individuals belonging to each group does not happen smoothly. Reactions in all possible stages are present at the same time. All the subgroups of the Ommoord central team had their internal problems or difficulties with one of the other groups; the doctors, for instance, had to tackle the problem of creating a satisfactory working relation with the four secretaries, in combination with the part-time advising manager, who suddenly had to form a team of their own. We have not yet solved all these problems.

Figures 1–4 can also be used in another way—for the stages of relationship process in every subgroup. For instance, every general practitioner is represented by a circle which partly covers the goal—the group practice—and on the other hand shares a part with the other doctors' circles, with the possibility of relationship problems; finally a doctor or other team member keeps a private part of the circle for himself.

Group standards partly determine the size of this private piece. This is a major problem. Which standard determines what and who makes the rules? In 1970 the lack of unanimity about these rules and other kinds of relationship problems made the doctors decide to take action. With assistance from Professor A. Hazewinkel, a psychologist and specialist in group and organisation psychology, they began a course of sensitivity-type meetings as a possible cure for this relationship disease.

Each doctor took part and discovered how difficult things were and why business meetings were slow and ineffective because of the large number of personal problems between members of the group practice. Most decisions proved to be meaningless, because they were made ineffective by personal differences. Every decision ran this risk and the following list of narrow escapes is impressive. All these decisions were ' infected ' though ultimately achieved:

(a) Reshaping and reforming habits of working to make the totality as homogeneous as possible (differences in accuracy),

(b) The ' foreign policy ' of the group practice (relations with other organisations connected with primary health care),

(c) Methods used to exchange information,

(d) Difficulties in dealing with secretaries and other members within the team,

(e) The size of the population of patients,

(f) Legal contracts and financial arrangements.

After a year and a half we still stumble occasionally, but less often and more adroitly. At least it is now possible to guard traffic at the more dangerous intersections, so that the roads can be used. Members have learned to be more aware of relations, and shifts in relationships are no longer ignored, thus providing an inbuilt safety catch in the weekly decision-making and planning. The subteams had similar training sessions in the first half of 1973, when on a larger scale such initiatives were taken in Dutch primary health care projects. The subteams too are still far from finding a complete solution.

What is a group?

Thelen's (1968) book on group dynamics was useful to us in identifying the following characteristics of a group:

TABLE 1

THE CHARACTERISTICS OF A GROUP (THELEN, 1968)

(1) Defined membership,
(2) Members think of themselves as members of a group,
(3) A sense of shared purpose,
(4) Relative greater ease of communication among members,
(5) Sense of approval for himself, feedback from others in the group,
(6) An obligation to respond to the behaviour of others in the group,
(7) Expectations of group behaviour in various situations,
(8) Leadership policies and roles,
(9) A status system, a hierarchy of worth of individuals to the group,
(10) Shared responsibility for the common purposes of the group.

These characteristics may seem obvious, but they took a long time to be accepted by all members of the team. For the central team the most difficult issues were the feeling (or lack of feeling) of being accepted, the existence of (un) official leadership, elements of social status, and the limitations of a team with a clearly defined common goal.

Earlier the doctors as a group had to deal with these issues in the same order.

Some problems took much time, for instance, the acceptance of the two women doctors by the four men. Until the end of the training course the men and women general practitioners felt differently about the combination of wife, mother, and doctor at the same time. Emancipation does not always flourish in our climate.

Exclusiveness of membership

There is a tendency in a team like ours to overlook the fact that every individual is a member of other groups too and that these exert a varying influence, though mostly undercover. During the early history of the Ommoord team there were conflicts with the various professional background structures of each discipline. Aggression against group practices and health centres from medical organisations gradually died down, but still every day brings confrontation with traditional ideas about the general practitioner, especially from the patient's side.

Being a member of a ' hangover group ' is determined by stereotyped behaviour acquired in early youth, as seen in tendencies to passivity, rivalry, and conflict with authority. Thelen speaks of the existence of a fantasied group or dream team that fulfils everyone's emotional needs, solves hidden fears, and acts as a refuge. Whenever dream team and actual team diverge too widely life gets difficult for a member of both.

In Ommoord, members of the team often reacted with (stereotyped) aggression to the lack of enthusiasm and criticism that came their way from the patient or client (the so-called take-it-or-leave-it method), while in reality it was the feelings of insecurity of the group member which were at stake.

Another example was seen when the doctors could not decide on the right method of equalising previous differences in population size and income. These kinds of problem are apt to upset relationships and never come at an appropriate time. Endless discussions with all sorts of pseudo-financial arguments took place, while the real conflict was an emotional one. An effective decision could not be made before everybody ventilated his anger and hurt pride. Afterwards a decision could be made without adverse effect on the group. A fake decision makes more and more subsequent decisions necessary, and makes them harder and harder to obtain (table 2).

TABLE 2
PROBLEMS FACING ALL GROUPS (THELEN, 1968)

(1) The ' official ' problem the group has to solve,
(2) The hidden problem of dealing with shared anxieties,
(3) Individual efforts to achieve publicly-stated ends,
(4) Efforts by individuals to deal with their own hidden problems.

So far words such as ' problem ' and ' difficult ' have been used more often than words like ' satisfactory ' and ' comfortable ', which may easily cast gloom on the reader. To the workers in the Ommoord health team, however, the positive aspects prevail.

Working in a team like ours bears a profound resemblance to marriage, being the result of the longing for the deep peace of the double bed after all the hurly-burly on the chaise longue.

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