EDITORIALS

Teams for the year 2000

TWENTY-FIVE years have passed since the first experiments in practice attachments of health visitors, and it is 20 years since the Standing Medical Advisory Committee recommended that fieldworkers such as nurses, midwives and health visitors should be attached to individual practices (Central Health Services Council, 1963; Reedy, 1977). Over this period we have seen rapid growth in the number of practices with attached local authority staff and directly employed nurses, so that currently at least 70 per cent of general practices in Britain have one or more nurses 'attached' to them.

There is little published evidence of effective teamwork, however. Many studies highlight the problems that nurses and doctors have in working together (Gilmore *et al.,* 1974; Beales, 1978; Bowling, 1981). Many senior nurses and health visitors express doubts about 'attachment' as a means of co-operating in primary care. Even when members do consider that their teams function satisfactorily, that function is usually 'co-active'. Primary care team members work independently, there is little need to co-ordinate their specialist tasks and they have independent learning requirements. As a general rule, work is passed from one discipline to another by delegation—and not a little interdisciplinary bickering—and joint activity is minimal.

Whatever the situation in the past, it will not do in the future. Four factors will see to this. First of all, and fundamental, there is the fact that the primary care needs of the community are multidisciplinary and cannot be provided by one individual, and therefore, like it or not, nurses and doctors will continue to have to work together in some way. Secondly, society's needs are changing: we are seeing a shift away from the management of acute and largely self-limiting illness towards the management of chronic illness and the anticipation or prevention of illness. Thirdly, the community looks to the practice with its registered population for primary care, and the practice-based team is best placed to provide this care. Fourthly, primary care teams will have to function interactively if they are to identify and meet the changing health care needs of society. In full consideration of the nation's economic resources and within the limits of their skills, team members must see themselves as providers of health care to a registered practice population. Interactive teamwork requires that the health care needs of a practice population be analysed and broken down into objectives at practice level by nurses and doctors working together as recommended by the Panel of Assessors for District Nurse Training (1978). The implications are that there will be changing ideas about what it means to be a district nurse, a health visitor or a general practitioner and that role changes will be geared to the needs of the practice population and away from professional independence and self-sufficiency.

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Changes of this magnitude involve profound attitudinal shifts and present an enormous educational challenge, but they must be acknowledged as the major targets for the year 2000. The problems cannot be overstated. Thwaites (1982) described difficulties in establishing motivation and co-operation when nurses, health visitors and medical students came together on a course: the junior medical students expected team dominance and leadership to be theirs as of right. Brooks and colleagues (1981) found that a study day for trainee general practitioners, student health visitors and student district nurses was successful in outlining the difficulties faced by team members. It seems that, even before they join teams of their own, student district nurses have a distrust of general practitioners, while general practitioner trainees are dubious of the value of health visitors—revealing, no doubt, the attitudes of those who teach them. However, there is encouraging anecdotal evidence that interdisciplinary groups of trainees function better when 'role playing' a primary health care team tackling clinical problems and providing problem lists on families, using case histories or video material.

There have been major steps forward. The Joint Working Group of the Medical Advisory Committee and the Nursing and Midwifery Advisory Committees has produced a definition of a primary health care team.

> "An interdependent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members so that they all pool skills and knowledge to provide an effective primary care service."

Within such a definition, teachers in all disciplines can discuss and develop educational objectives. Then, the introduction of the Nursing Process (Kratz, 1979)—assessment, planning, implementation and evaluation—could lead to independent decision-making and professional autonomy for nurses, and the development of university departments of nursing is likely to produce a generation of nurses who will see many new opportunities in primary care.

As a further step towards interactive teamwork, undergraduate education will need a new direction. Community medicine must receive equal emphasis along with laboratory and hospital medicine (Metcalfe, 1979). There must be greater co-operation between teachers, whereby medical teachers meet with lecturers in health visiting and district nursing. In postgraduate education, too, trainers' groups must include district nurse practical-work teachers and health visitor fieldwork teachers. The practice should be the training base for district nurses and health visitors as well as for general practitioners, so that training and experience are combined and so that learners can develop positive attitudes together rather than negative attitudes in isolation.

Welch (1979) has provided some figures. There are about 800 teaching practices for general practitioners, 1,000 district nurse practical-work teachers and over 800 health visitor fieldwork teachers; 26,400 general practitioners, working mainly in group practices, compared with 12,000 district nurses and 8,500 health visitors. Following basic training, general practitioners and health visitors spend 12 months in the community compared with six months for district nurses. A longer training period in the community will be required for the district nurse of the future. If training is to be based on the practice, there will have to be representatives of the team on the Joint Committee on Postgraduate Training for General Practice and selection of training practices in accordance with their ability to teach the team.

The sharing of premises is already happening. The sharing of training might be an encouragement to other sharing, such as the sharing of care and responsibility, and rewards (financial and status). Optimum team function should be the concept of team leadership rather than licence to tell other professionals what to do and how to do it. Perhaps we will see the introduction of partnerships for some nurses. If nurses are treated as part of a practice rather than an appendage, they might then feel a greater commitment to its aims. Perhaps the core team of nurses and doctors will begin to extend further, to include social workers, clinical psychologists, occupational therapists, dietitians, community psychiatric nurses, dentists, pharmacists and community medical officers—according to the needs of the community, which will vary geographically and in time.

All this can happen if the different disciplines involved want it to happen. Otherwise, it is not too fanciful to envisage the gradual fragmentation and ultimate breakdown of general practice and primary care nursing as we know it. We have already seen evidence of hospital-based 'take-overs' of primary care functions in obstetrics (hospital-based community midwives), paediatrics (home nurses), psychiatry (community psychiatric nurses) and surgery (stoma care nurses); warnings have already been sounded by a general practitioner (*Update,* 1982) and a nurse (While, 1981). Such warnings are not simply narrow-minded demarcation disputes. As Metcalfe (1979) pointed out, the hospital services are not geared to cope with the primary health care needs of the community and are bound to perform badly because they function best at finding and rectifying pathophysiological conditions in a referred population. Any attempt by hospital-based services to meet primary care needs on a significant scale will fail and lead ultimately to the destruction of the National Health Service.

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