

# Teams for tomorrow — towards a new primary care system

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**T**HE health care system in the United Kingdom has altered little since the nineteenth century. There have been catalysts for potential change, such as the National Health Service and the development of high technology medicine, but when change in the system has occurred it has not been a response to a desire for better health as might be expected but a response to the interplay of less admirable forces. These include the self-interest and innate conservatism of a powerful medical profession, the emerging independence and assertiveness of nurses, the desire within society for immediate relief of discomfort or distress and the concern of government with spiralling health costs.

## The origins of our present health care system

The origins of our primary and secondary care delivery systems can be found in a different society. In the nineteenth century the acute infectious diseases kindled by nutritional, environmental and educational deprivation were major causes of mortality and morbidity. The young population maintained by a high birth rate and a high perinatal mortality rate was clearly divided by a class system. It was expected that health care should be delivered on an authoritarian and paternalistic basis. A conservative and high-minded profession responded nobly to the demand made on it as all agreed that health was a commodity which was in the gift of doctors. The National Health Service was introduced in 1948 not to challenge this concept but to ensure that medical care was distributed to everyone irrespective of income or health problem.

## The new health care needs

Society now has new health care needs. Infectious diseases have disappeared from the mortality tables — scarlet fever killed three of my mother's siblings in the space of one week in the 1920s and even rheumatic heart disease, still prevalent in the 1960s when I qualified, is hardly a problem today. The major problems at present include the prevention and treatment of ischaemic heart disease and the prevention and treatment of cancer. However, society also faces two major social changes: an increasing number of older people and large numbers of unemployed young people, both groups likely to make substantial demands upon health care resources. In addition, one-third of all marriages end in divorce and many families have problems which are presented to the primary health care services. Psychosocial problems can be expected to form a significant part of the primary care workload in the year 2000.

## The problems

The impact of changing health care needs on an antiquated system has produced problems in the recent past. The diseases may have changed but people have not. Patients still complain of the same discomforts and distresses — minor respiratory diseases, emotional highs and lows, simple skin disorders and gastrointestinal disturbances. General practitioners in 1948 stated

that they were seeing many patients with trivial complaints; they blamed the new health service when what was changing was society. Trivial complaints are still trivial complaints even when presented by the rich — when given the opportunity everyone will seek relief from their distress. Balint taught us to understand this but the remedies in the doctors' armamentarium get ever more sophisticated.<sup>1</sup> Iatrogenesis has become a major feature of present health services, both in the form of over-prescribing and a soaring drugs bill and of social disorders as so many aspects of human life are medicalized.<sup>2</sup>

## Towards a new system

Any new health care system must restore personal responsibility for health care to the population. Self-care and patient participation must be features of the system. There must also be a shift in emphasis from the treatment of acute self-limiting illness to prevention and the care of major chronic illnesses. Finally, patients and doctors must make full use of new information technology and the second industrial revolution. These changes require new attitudes and new skills on the part of the doctor the most important of which may be the ability to enable patients to overcome the obstacles which prevent them making behavioural changes for a healthier life. Since health is no longer in the gift of doctors and since so many different skills are required no one profession can cope alone. Added to this, the need for easy access, economy and a flexible response to changing demands for care, make an overwhelming case for the development of an effective primary health care team.

## Teamwork in the year 2000

Several studies have reported the difficulty team members have in working<sup>3,4</sup> and learning together.<sup>5</sup> Lists of problems can be drawn up and at the personal level these include needs, wants, expectations and role modelling. At the operational level the different system of employment for doctors and nurses in the National Health Service (one being an independent contractor and the other a salaried employee of the health authority) cannot make for effective teamwork. Job demarcation disputes are common and in order to overcome these the concept of the practice nurse has been introduced in many practices. This may result in comfortable relationships but may impede the development of nursing as a profession and primary care nursing in particular because team members cannot develop their full potential.

The way in which a group can function varies. Coactive behaviour is common — people work alongside each other but separately. An example would be medical and surgical outpatient clinics taking place in the same hospital on the same afternoon. Medical staff and surgical staff are both interested in the better health of their patients yet tend to work independently, to develop little cooperation, to set individual rather than joint goals and to see little point in joint training.

A second type of behaviour is interactive behaviour, for example a football team whose members have a common purpose but different roles and responsibilities. In the United Kingdom primary health care team members could share professional responsibility for a practice population registered with the team and not with the doctor. Young trainees of all disciplines will be providing care well into the twenty-first century and the definition of health visitor, district nurse and general practitioner will certainly have changed by then.

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Interactive work would enable the health care needs of a practice population to be broken down into health care objectives; this requires communication, adaptive and interpersonal skills and the full understanding of the roles of different team members.

### A model for team function

Two concepts seem relevant to the desired changes in the health care system — the concept of coactive and interactive behaviour and the concept of individual professional autonomy and hierarchical control. These polarities can be plotted in diagram form (Figure 1) as a model for team function.

Quadrant A behaviour is characterized by smooth working relationships but a poor and expensive service because some team members cannot develop their full potential, for example the directly employed practice nurse. There may be some shift to quadrant C behaviour (towards greater professional autonomy) but interactive behaviour is unusual. Any movement towards greater professional autonomy seems to be accompanied by interdisciplinary friction but this should be seen as a mark of pro-

gress rather than of failure and the temptation to work for greater medical control of nurses should be resisted.

Quadrant D behaviour allows the full professional development of team members who will attain the limits of their skills while adjusting to the changing needs of the community.

Quadrant B behaviour is internally inconsistent and any tendency to move towards it is characterized by team conflict.

### The process of change

Changes of this magnitude require a complete review of educational goals at undergraduate and postgraduate level for all relevant disciplines but there is much that we can do now in our own practices. The ideal team relationship seems to be a dynamic equilibrium between quadrants C and D and we can encourage this.

First, we should develop the concept of the teaching practice as a teaching base for health visitors and district nurses in training as well as for general practitioners. An effective team must be a criterion for the appointment of a teaching practice and this must be laid down by the Joint Committee on Postgraduate Training for General Practice. Trainer's groups must have meetings with health visitors, fieldwork teachers and district nurse practical work teachers. Trainees of all disciplines must meet together on release courses.

Secondly, we must work towards a system where the input and ideas produced by all disciplines are equally valued. Health visitors have already achieved a considerable amount of independence. The concept of the independent nurse practitioner with new skills and attitudes must be developed. These nurses and the health visitors should be partners in primary health care teams owing their allegiance financially and professionally to the practice as general practitioner principals do at the moment. All professions should be administered by new independent family practitioner committees with adequate representation by nurses. If general practitioners are prepared to participate in a care delivery system in which each team member is rewarded according to his value to the team partnership and to the community, nurse managers must be prepared to preside over their own eventual extinction, for the greater good of the community and nursing as a profession.

### The rewards

Practice nurses, general practitioners and health visitors (and other team members as needs develop) will find their own level in the same structure of care. Interactive and coactive teamwork will develop and evolve in the best interests of patients and team members. The greater health of the community is but an attitudinal step away.

### References

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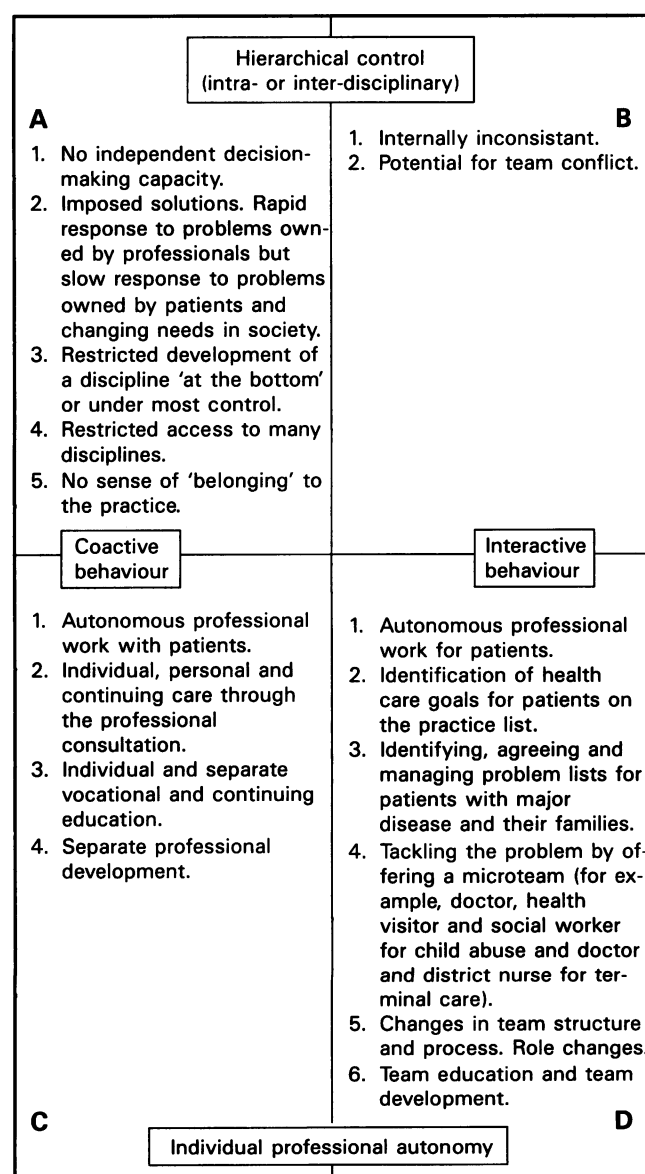


Figure 1. The primary health care team — a model for team function.