needs of doctors and nurses should be addressed and the development of specialist community nurses for elderly people further investigated.

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Partners in Practice

The developing primary care partnership

Mike Pringle

This is the last of a series of articles focusing on the current tasks and functions of the primary health care team

This series of articles has looked at a number of key issues in teamwork in primary care. It is clear that if a clean start could be made, primary health care teams would probably look substantially different from the ones we encounter today. The historical development of primary care has resulted from three concurrent pressures—political, organisational, and clinical.

Development of primary care

The existence of primary care teams can be largely attributed to the 1966 charter, which also limited the range of skills available within the team. The rules for reimbursing 70 per cent of staff costs defined eligible job descriptions; if that list had included physiotherapists, social workers, or counsellors the nature of primary care itself over the past 25 years would have been radically altered. The recent relaxations have given practices much more discretion but have also introduced the possibility of a lower reimbursement.

The second pressure has been organisational. The moves towards group practices, practice reports, audit, and computerisation have all emphasised the need for administration and management. The increasing sophistication of practice information systems for managing both clinical care and the resources of the practice has reached its apotheosis in fundholding. Practices joining this scheme require a level of internal organisation that would have seemed unachievable and unbelievable a decade ago.

Perversely the increasing management role in primary care has resulted in less involvement in management by some doctors. The arrival of practice managers with high level skills has freed general practitioners from administration and often from direct management responsibility. The increase in clerical staff has given the practitioners support with

Key points

- The primary health care team as we know it has developed largely in response to political, organisational, and clinical pressures
- Education is required for team members deficient in necessary skills
- The personal responsibility of each member within the team framework must be identified and accepted
- Patients should encounter the teams, not unconnected coworkers
- Every member of the practice should participate in quality assurance
- The result of effective teamwork should be, primarily, an increased quality of care

paperwork that their colleagues of 1966 could only envy.

The third major pressure derives from clinical evolution. In recent years there has been an accelerating transition of medical care into general practice. Child immunisation, developmental assessment, and family planning have been shared with agencies in district health authorities, but the 1990 contract has often led to their transfer to primary health care teams. The national surveillance of the "healthy" population through well person clinics, visits to the over 75s, and new services such as foreign travel clinics has augmented the workload and responsibility of primary care.

Through the 1980s there has been a shift in the care of patients with chronic disease from secondary care into general practice. The closure of many psychiatric

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Real teamwork entails patients encountering teams and not, for example, seeing doctors and nurses separately

hospitals, with the transfer of their longstay patients into the community; the move to offer routine management of many chronic illnesses—for example, hypertension, asthma, myxoedema, diabetes, and epilepsy—in general practice, which has removed most of these patients from hospital follow up; and increasing open access to pathology and radiology services and treatments such as physiotherapy and minor surgery, has reduced the requirement for hospital referrals.

These three historical trends have clearly created the head of steam that has driven the primary health care team forward for nearly 30 years. In the process many serious structural and process problems have been created, which we ignore at our peril.

Current problems facing primary health care teams

What is a team? A team is more than a list of coworkers in a practice report, although that may vary widely. If a team is to mean anything it must embody a method of working, a process not a structure.

In all too many practices the team rarely meets. Care is transferred between team members with the minimum of consultation and tasks are delegated without proper communication and education. All too often protocols for major diseases are written by doctors without team discussion, but implemented by practice nurses without training.

QUALIFICATIONS AND SKILLS

Some team members have been recruited with inadequate qualifications. Some practice nurses are ill equipped for their job, and many dispensers are barely trained receptionists. Deficiencies in skills result in reduced self confidence, and then a loss of respect within the team. So a first strategy must include improved standards in staff appointments allied to education for those in post.

Once all team members are secure in their skills they need to be valued. Only if their opinion is sought, and reacted to, and they are then involved in implementing subsequent changes, will practice team members feel as if they belong to a real team.

REAL TEAMWORK

Increasingly practices will examine whether clinical care is really given by a team or individuals. Even antenatal clinics—a paradigm for interdisciplinary working—are often only a method of duplicating effort, with genuine dual consultations being rare. Many “health promotion” protocols for monitoring

diseases entail doctors and nurses seeing patients separately. If the team approach is to be a reality the patients must encounter teams, not just unconnected coworkers, each with clearly defined areas of interest.

Doctors and nurses often choose to work in primary care because they value their autonomy. They seek and prize a personal responsibility direct to the patient. The ethos of working in a team conflicts directly with this desire for autonomy, and this tension needs to be acknowledged and discussed. Only when all team members can identify their personal responsibility within the team framework, and are comfortable with that allocation, will “the team” be given more than lip service.

This in turn requires the leadership role to be shared. The general practitioners, traditionally the owners of the practice in every sense of “ownership,” understandably often see themselves as the employers with the ultimate control. They may dispense some power, but only conditional on their ability to retrieve it when necessary. The perceived and tangible hierarchy in general practice perpetuates the status of nurses, practice managers, and attached staff as coworkers rather than team members.

EDUCATIONAL NEEDS

Another problem concerns the educational needs and experience of team members. The doctors have their needs recognised and encouraged by the post-graduate education allowance, but practice nurses and managers are dependent on the goodwill of the practice and the whims of the family health services authorities for their educational needs being met. When education occurs it is common for team members to undertake it separately.

AUDIT

The last major problem concerns quality. Medical audit is slowly establishing itself, but it needs to be widened to include all the clinical, managerial, and administrative members of the team. It may be satisfactory to start by auditing the medical content of a diabetic clinic, but the nursing input also needs auditing, as does the appointment availability, the timing of the clinic, the information given to patients and their satisfaction, and, of course, the outcome. Everybody, including the receptionists, needs to be involved in such quality assurance.

Auditing will have a positive feedback on performance only if the responsibility for the work and the results are shared among those concerned. If tasks are delegated without information, training, and support the team member cannot then be held accountable for the result.

Future possibilities

FINANCIAL REWARDS

Many of these problems will be addressed as primary care evolves. Fundholding practices in particular are undergoing a culture change to one that values every patient contact, and will increasingly raise the status of all team members. All practices will eventually confront the need to offer more than psychological rewards to all key team members. Performance related pay is increasingly being discussed, but few practices have found a satisfactory formula. The definition of “performance” is problematic, as is the nature of the reward.

One solution which seems to be gaining credibility is to offer key members of staff—practice managers and nurses, for example—a partnership share. Although this share would not be equal to that of a medical partner, it would allow all senior team members to share in increases in practice profitability by having a

mutual stake in increasing income and controlling expenditure.

NURSE PRESCRIBING

As nurse prescribing moves up the agenda, wise practices will realise the implications for indicative drug amounts and fundholding budgets. The more the nurse feels ownership of the practice's finances the more likely is nurse prescribing to relate harmoniously to that of the doctors.

COMMUNITY NURSES

It seems probable that community nurses will become more integrated, not less, with the primary health care teams, perhaps as practice employees, or, more likely, as community unit employees sub-contracted to the practice. Only practices that have a good system for integrating and valuing all their staff will succeed in welcoming the currently attached staff into full team membership.

CHANGES IN ATTITUDE

By redefining the definition of a "partner in the practice" the structural problems in motivating senior members of the team may be overcome. But the behavioural problems will remain. Doctors will increasingly have to accept the primacy of others in areas where their skills are traditionally less developed, in particular in nursing and management. The problems of integrating some team members up into the centre of the practice will be mirrored by the problem of integrating the doctors down into the centre.

A good place to start is the identification of common tasks and the requirements to meet or improve the performance of those tasks. The requirements may be educational or managerial, clinical or organisational. By working together towards common goals team members can learn to value each other.

For most practices this will not require outside experts—facilitators, management consultants, or gurus—but internal re-evaluation and discussion. If an event such as changes in staff is used to trigger this process then the practice needs to be primed to react positively. At present the most common precipitant is fundholding, but this need not be the case.

The end result should not simply be better work relationships or even greater financial efficiency, although both of these are laudable. If the primary health care team is to achieve anything it must increase the quality of health care. The evidence for its success must therefore rest on the services offered and their standards. This is the holy grail to be unearthed by the attitudinal, cultural, change ahead.

Conclusions

Given a clean start, nobody would create the structure and process of the current primary health care team. If we can espouse a coherent vision of the future for the team, such as has been put forward in this series of articles, then methods for evolving towards it can be found.

The key element in this vision of the future is that all team members must be valued as skilled professionals in their own right. That implies responsibilities—on them to gain and retain skills, and on the practice to motivate them—but it does not imply wholesale structural change. New organisational techniques will be needed and the notion of "partnership" redefined, but if the primary health care team of tomorrow is to work it must be characterised by quality caring—quality caring for patients and quality caring for each other. That is easy to conceptualise but, like all cultural changes, difficult to make happen.

This series has been edited by Dr Mike Pringle.

ONE HUNDRED YEARS AGO

EVERYBODY'S MEDICAL DUTY.

Herodotus tells us that the Babylonians had no physicians, that when anyone was sick he was carried into the streets and placed where the greatest number of passers-by could see him; everybody was bound to stop and consider the case, and if an individual paused who had suffered in what seemed to him a similar manner he was compelled to explain the method of his cure. There is no necessity for this sort of thing now, although a large section of the public enjoys nothing more than suggesting remedies for all sorts of complaints and dabbling generally in a little physic. But there never was a time in the history of civilisation when there was greater need that everybody should recognise the fact that he owes a medical duty to his neighbour which he is bound to perform.

Dr. George Gould recently delivered an address in Philadelphia on the subject "Everybody's Medical Duty," in the course of which he bitterly complained of the way in which the public at large leaves the medical profession to struggle under its Atlantean world of deputed responsibility. The indifference, the want of sympathy, to say nothing of the actual opposition experienced by those whose work it is to contend against disease is as discouraging to our profession as it is disgraceful to our age of science. There never was a body of men animated by a spirit of devotion and self-sacrifice such as characterises the medical practitioners of the age. How is this devotion

and self-sacrifice recognised? The quacks, the charlatans, and the knaves make fortunes, while educated and conscientious practitioners are expected to do a large amount of work for nothing. Up to now the work of the physician has been the cure of sick persons. Now it has largely become the prevention of sickness. Patients will co-operate more or less in the work of being healed of their diseases, and are not wholly ungrateful to the healer, but those who are in daily danger of becoming patients will do little or nothing to assist the men who are fighting to keep disease from their doors. They laugh at bacteria and mock at microbes; carry the germs of disease in their clothes from house to house; sweep up the dust of the streets in their trailing skirts; take little or no pains to disinfect the excreta from such infectious cases as occur in their own homes; oppose with all their influence the erection of hospitals for infectious diseases in their midst, careless as to what becomes of the patients so long as they pass not by their own doors; impede the efforts of medical officers of health and inspectors of meat and other food to improve the hygienic conditions of our towns and the quality of the food we consume; disregard the authoritative condemnation of the corset; and in a multitude of ways help to make the work of the modern physician as hard as possible. Chaldea and Babylon could have taught us this, at least, that everybody is bound to help the State to the utmost of his power in the battle against disease and death.

(*BMJ* 1892;ii:141)