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 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 apothecosis 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
paperwork that their colleagues of 1966 could only
envy.

The third major pressure derives from clinical
evolution. In recent years there has been an acceler-
ating 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 roles such as foreign travel clinics has aug-
mented 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
to general practice. The closure of many psychiatric
hospitals, with the transfer of their longest patients
into the community; the move to offer routine manage-
ment of many chronic illnesses—for example, hyper-
tension, 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 treat-
ments 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 hier-
archy in general practice perpetuates the status of
nurses, practice managers, and attached staff as co-
workers 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 of timeliness, 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 perform-
ance 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
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.