changes in colour and consistency.[5] Thyroid function tests, isotopic imaging of the thyroid gland, chromosomal studies, and urinary mucopolysaccharide assay may be indicated. Patients with chronic airway obstruction should be assessed for pulmonary hypertension and cardiac decompensation with electrocardiography, chest radiography, arterial blood gas analysis, and Doppler echocardiography. Computed tomography and magnetic resonance imaging may be useful to delineate soft tissues and to show the extent of tumours and other masses. Microscopic examination of tongue tissue in primary macroglossia may be unhelpful, but biopsy is useful for localised lesions of the tongue that occur in chronic granulomatous and neoplastic disorders. Biopsy of other potentially affected tissue (rectum, skin, gums) is indicated to diagnose definitively amyloidosis.

The successful management of macroglossia requires a multidisciplinary approach. Medical management may be sufficient if the enlargement of the tongue is due to systemic disease, but surgical reduction offers the best functional and cosmetic results and minimises morbidity. Airway obstruction demands prompt intervention; tracheostomy is occasionally necessary. Surgery is indicated in almost all cases of secondary macroglossia, when the tongue is affected with neoplastic disease. In primary macroglossia in infants, prevention of speech and orthodontic problems may require surgical reduction of the tongue at an early stage, preferably before 7 months of age.[6] Early management helps rehabilitation and reduces the risk of permanent maxillofacial abnormalities and abnormalities of speech.

Conservative methods of treating macroglossia are of limited value. Thyroxine in cases of hypothyroidism and bromocriptine in cases of acromegaly have obvious therapeutic benefits. Corticosteroids can be life saving in acute airway obstruction and are useful postoperatively to reduce oedema.

Reduction glossectomy has been the main surgical treatment for patients with symptomatic macroglossia.[7] Excision should be conservative whenever possible, particularly with benign disease, to allow the tongue to fit comfortably in the oral cavity and restore normal occlusion.[4] Surgical techniques offer a choice of a V shaped wedge resection, circumferential wedge resection, or a combined transoral and transcervical approach for grossly enlarged lesions.[8] Whatever the technique, particular attention should be given to preventing acute airway obstruction; tracheostomy is usually required to cover the perioperative period.

Patients with macroglossia face appreciable physical and psychological problems requiring support and rehabilitation. Secondary orthodontic care and speech therapy may have important roles in this. The stigma attached to an enlarged tongue protruding outside the mouth, labelling the patient (particularly a child) as having learning disabilities, causes substantial mental anguish to patients and their families. In older children these psychological burdens often result in depression and withdrawal. In some cases psychiatric help may be needed; in most cases long term counselling and support are essential to enable patients to achieve mental stability, overcome prejudice, and reintegrate into society.

P MURTHY
Registrar in otolaryngology
M R LAING
Consultant otolaryngologist

Raigmore Hospital NHS Trust,
Inverness IV2 3UJ

1 Gupta OP. Congenital macroglossia. *Arch Otolaryngol* 1971;93:378-83.
2 Weiss LS, White JAJ. *Journal of the Louisiana State Medical Society* 1990;142:13-6.
3 Rizer FM, Schechter GL, Richardson MA. Macroglossia: etiologic considerations and management techniques. *Int J Pediatr Otorhinolaryngol* 1985;8:225-36.
4 Myer CM, Hotaling AJ, Reilly JS. The diagnosis and treatment of macroglossia in children. *Ear Nose Throat J* 1986;65:444-8.
5 Dolan EA, Riski JE, Mason RM. Macroglossia: clinical considerations. *International Journal of Orofacial Myology* 1989;15:4-7.
6 Shafer AD. Primary macroglossia. *Clin Pediatr* 1968;7:357-63.
7 Vogel JE, Mulliken JB, Kaban LB. Macroglossia: a review of the condition and a new classification. *Plast Reconstr Surg* 1986;78:715-23.
8 Dinerman WS, Myers EN. Lymphangiomatosis macroglossia. *Laryngoscope* 1976;86:291-6.

The primary health care non-team?

Small groups set up to perform specific tasks are preferable to teams with nebulous aims

Is the primary health care team a myth? Teams can be defined in a variety of ways—whether as "beasts of burden yoked together" (*Oxford English Dictionary*) or "a small group of people who relate to each other to contribute to a common goal."[1] Successive governments and professional organisations have advocated the creation and maintenance of "the primary health care team."[2-5] Teamwork in primary care, it is suggested, is the way forward, and by implication, the way to achieve high quality care for patients. But what is the evidence for this and what are we aspiring to? Do we have teams or non-teams?

The literature yields few empirical data on the topic. Work in Newcastle upon Tyne indicated some consensus among practitioners regarding core participants, who generally include medical, nursing, and reception staff.[6] But much less agreement exists regarding membership of the extended team—members are drawn in as necessity dictates. Some of the variation in composition may be attributable to differing definitions of the team, depending on whether shared function, employment status, or clinical practice is its defining characteristic.

Gregson and her colleagues looked at the collaboration of doctor-nurse pairs and concluded that factors such as a shared base (for example, in a health centre) and stable attachment were important in encouraging such collaboration.[7] More recently the same unit has described some of the misunderstandings and mismatches of perception among members in 20 practices in Northumberland.[8] This confusion reflects the experience of many practitioners for whom teamwork is rhetoric rather than reality.

Theories of organisational development provide a useful framework for examining issues arising from this debate. Plant's iceberg process suggests that important factors in an organisation's capacity to develop fall into two groups —the formal and the informal. Formal factors are "visible" and include policies, objectives, systems of communications, and job descriptions. Informal factors are submerged and include informal relationships, power networks, values, and norms.[9] Theoretically, formal factors may be changed in rational and open ways. Informal factors are less likely to be tackled directly.

Anecdotally, practitioners often cite working on shared

tasks as the time when they perceive themselves to function best as a team—whether in caring for a dying patient, installing a new computer, or setting up a new service. Government rhetoric also defines the primary health care team as centred on a shared task or function—the achievement of the health of the nation through the provision of health care and promotion of health. Shared objectives are part of the visible team. Working together also generates informal communication; Plant's model suggests that informal relationships are an important element of the submerged team.[9]

What then of the enthusiasm for team building? This developed in the late 1980s, when Jones published his work on multidisciplinary training[10] and the Health Education Authority developed its concept of local organising teams to promote teamwork in health promotion.[11] Many models have since developed, but undoubtedly the idea of increasing teamwork in primary care has taken hold. Is this the right move for the wrong reason—the right move because people working in primary care need to work together efficiently and effectively; the wrong reason because focus and clarity are often lacking and we need to move on from process to look at ways of intervening to deliver specific outcomes?

Tip of the iceberg

Team building initiatives are usually directed at the formal and visible aspects of the organisation, which was the case with the strategies suggested by Atkinson and Hayden in the *BMJ* in 1992.[12] Although team building initiatives can be effective in improving process,[13] some people may need to change more than others. Values and norms are part of the submerged aspects of the organisation. When one looks at people who less often feel part of the team, their work is often marginal or their role ill understood.

Health visitors are one such group. Cowley has argued (personal communication) that the health visitor's role is to be marginal to other services, neither part of the primary care team's world nor part of the patient's world. The underlying principles of health visiting—identifying health needs, enabling people to take control of their health, influencing policies affecting health—rest awkwardly with the essentially curative values of other team members and are often unrecognised. Another simpler possibility may also apply: health visitors' direct interaction with general practitioners is often limited—perhaps amounting to a shared child health clinic. Health visitors' colleagues in district nursing tend to have daily interaction with general practitioners, if only (at present) to get prescriptions signed. The opportunities for developing informal relationships and a clearer understanding of roles may thus be enhanced.

Clearer formal aims and objectives and a better understanding of each other's roles and skills may produce better outcomes—but evidence for this is lacking. People undoubtedly feel better if process is improved, but the potential for inducing guilt exists if a complete team does not come about. Focusing on functional groups and measuring their success in terms of the outcomes for patients may be preferable.

The size of teams seems important. In smaller teams (possibly those with 12 or fewer members) all team members should know each other, be aware of and value each other's skills and interests, and share in setting and achieving goals. In teams of 25 or more people not everyone is going to share every goal and participate in every decision. The dynamics of individual professional subgroups will also create tensions within the organisation. The trends in primary care reviewed by Stott suggest that the concept of teams may be breaking down as numbers increase.[14]

Power networks among participants are a further submerged factor in the way in which teams or non-teams develop. Last year a nurse's refusal of a financial partnership with the general practitioners with whom he works attracted publicity. According to the *Nursing Times*, the nurse decided that he already had most of the rights within the team that he wanted; he feared that acceptance of such a role would lead to many practice nurses being regarded as somehow inferior because they were not partners. Although many nurses might regard themselves as working in partnership with general practitioners, employed staff—whatever their role—are likely to be at a disadvantage because ultimately the general practitioner has the right to fire them. While reporting relationships and organisational structures are part of the visible shape of a team, power networks are part of the invisible underwater bulk.

In this hierarchical context teamwork is arguably difficult if not impossible to achieve. In practice, even sporting teams have captains, though if they cannot keep the team together with regard to tactics spectacular failures can ensue. An imbalance of power is not itself a contraindication to teamwork—rather it reminds everyone of the need for effective leadership. When general practitioners do not agree among themselves or do not agree on who should lead—perhaps through excessive attention to the trappings of democracy—a cohesive team is unlikely to develop and survive. Team building activities can help to identify problems.

Although team building and teamwork skills are important ways of engaging isolated individuals and strengthening corporateness, teamwork takes place most effectively in the functional groups that provide patient care. These groups are small (perhaps two to five people) and focused on a single task—for example, care of patients with diabetes. Everyone's role should be clear. Leadership is taken on by the people most appropriate or committed to the task. Encouragement to develop a rather nebulous primary health care team should be replaced by an emphasis on cohesive multidisciplinary working to achieve clearly established aims and objectives.

PAULINE PEARSON
Lecturer in primary care nursing
KEVIN JONES
Senior lecturer in primary health care
School of Health Care Sciences,
Medical School,
Newcastle NE2 4HH

1 Ovretveit J. *Co-ordinating community care.* Milton Keynes: Open University Press, 1994.
2 Department of Health and Social Security. *Annual report.* London: HMSO, 1974.
3 British Medical Association. *Primary health care teams.* London: BMA, 1974.
4 Royal College of Nursing. *Primary health care nursing - a team approach (working party report).* London: RCN, 1980.
5 Department of Health. *New world, new opportunities: nursing in primary health care.* London: HMSO, 1993.
6 Pearson P, van Zwanenberg T. *Who is the primary health care team? What should they be doing?* Newcastle: Department of Primary Health Care, University of Newcastle, 1991.
7 Gregson B, Cartlidge A, Bond J. *Interprofessional collaboration in primary health care organisations.* London: Royal College of General Practitioners, 1991. (Occasional paper 52.)
8 Hutchinson A, Gordon S. Primary care teamwork: making it a reality. *Journal of Interprofessional Care* 1992;6:31-42.
9 Plant R. *Managing change and making it stick.* London: Fontana, 1987.
10 Jones RVH. *Working together—learning together.* London: Royal College of General Practitioners, 1986. (Occasional paper 33.)
11 Spratley J. *Disease prevention and health promotion in primary health care.* Oxford: Health Education Authority, 1989.
12 Atkinson C, Hayden J. Managing change in general practice: strategies for success. *BMJ* 1992;**304**:1488-90.
13 Pearson P. *Teamwork in primary health care: evaluation of a teambuilding programme.* Newcastle: Newcastle Community Health, 1992.
14 Stott NCH. When something is good, more of the same is not always better. *Br J Gen Pract* 1993;**43**:254-8.