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Commentary – Alma Ata

Myths and realities in multidisciplinary team-working

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One of the strengths of British general practice has been its interest in multi-disciplinary working – a key concept arising from Alma Ata. Collaborative team work has long been advocated as a means of providing effective primary health care.[1,2] The Royal College of General Practitioners distinguishes between a core primary care team of doctors, nurses and counsellors and a wider multi-professional network outside the direct managerial control of the general practitioners.[3] This is an important distinction with implications for current changes in general practice.

The early experiments in multidisciplinary working were lead by innovators who had little direct evidence of benefits to patients from greater team-working.[4] Their beliefs about the benefits of collaborative working were:

- care given by a group is greater than that given by one
- rare skills and knowledge are used more appropriately in teams
- duplication and gaps in care are avoided by team-working
- peer influence and informal learning occur within teams and raise standards of care
- team members have greater job satisfaction and are better able to cope with the stresses of working in primary care.
- teams contain the potential for developing more creative solutions to problems.

Multidisciplinary team development in general practice expanded from these innovative pioneers to the majority when the demands of the 1990 GP contract made the direct employment of nurses in general practice highly desirable.[5] This change in the core practice team was matched during the fundholding period by changes in the wider multidisciplinary network. The purchasing and/or commissioning roles of some general practices prompted closer working arrangements between community nurses and practices, including experiments with integrated nursing teams[6,7] Counsellors became similarly employable during the 90s.

The formation of practice-based teams was also a practical (if unintended) response to the growing anxieties about the sustainability of health service delivery in its usual forms. A joint statement on team-working in primary care published in 2000 by the Royal Pharmaceutical Society of Great Britain and the British Medical Association pointed out that the number of professionals (especially doctors) was unlikely to be sufficient to meet expectations for timely provision of high quality care if services continued to be organised in traditional ways.[8] In other words, team-working was not just ideologically gratifying for some, financially attractive for most, but also essential to avoid a crisis.

We can define three levels of team working:[9]

1 the nominal team characterised by professionals working apart but in contact
2 convenient teams, in which tasks are delegated down a hierarchical structure
3 committed teams, characterised by fully integrated working between disciplines.

The case of Vauxhall Health Centre, described in this edition of the *London Journal of Primary Care* is a good example of a committed team, with high levels of trust and mutual understanding. Different team members of this team will no doubt relate to a variety of nominal and convenient teams that operate beyond the practice walls.

All of these arrangements can be functional, both from the viewpoint of the professions concerned and from the perspective of those using services. In circumstances of high demand and relatively low resources streamlined working with limited communication is adopted for sake of efficiency. The most effective team building takes place when there is a clear practice-based project to be undertaken,[4] so practices facing increasing demands to standardise and improve the quality of care have developed convenience teams to tackle QOF targets.

Committed teams often arise from a shared project, perhaps a difficult case of palliative care, or the

management of drug misuse, or the care of older people. What can be achieved in terms of collaborative working is dependent upon demand and resources, mediated by the enthusiasm of professionals for joint working.

The problem with multidisciplinary team-working

In its early days multidisciplinary working in primary health care often failed to live up to its rhetoric, especially in the relationship between general practice and the wider network of disciplines.[10] Employment status differences, cultural differences between professions, geographical separation and membership of multiple teams were cited as real barriers to team working.[11,12] Physical proximity, social proximity and positive motivation are prerequisites to collaboration and team working.[13] The size of the team's membership also appears to be an important factor, with three to six offered as the most effective group size for decision making and communicating.[14]

However, the report by the Royal Pharmaceutical Society of Great Britain and the British Medical Association (2000) also points out that, despite the catalytic role of some professionals in different disciplines in promoting team-work, the first major obstacle to collaboration was professionalism itself. The second was the lack of a shared information technology that would allow the emergence of a common electronic patient record.

The benefits of team-working may be unevenly distributed across disciplines. There is evidence that co-location is seen by social workers as potentially isolating, and a challenge to social work practice[15] because the team working desired by GPs required social workers to adapt their behaviour and thinking to those of family medicine. Add to this view the fact that there is as yet little evidence that collaborative working between primary care and social services results in higher quality care, cheaper services or more satisfied patients,[16] and the case for close multi-disciplinary working collapses.

Teamwork can be stressful. Teamwork can expose role ambiguity and opposing values, and provoke interpersonal conflict.[17] Of course, we are bound together more by conflict than by agreement, but conflict requires harder work at communication. The rules of engagement bring people together, individuals and groups become better at listening and responding, and differences can be clarified as agreement is reached.[18]

Teamwork can be superficial. It may be presented as 'a culture of co-operation (promoted) through egalitarian symbols',[19] but may function as a form of deep acting,[20] creating masks of co-operation which establish the friendliness of the worker rather than his/her genuine concern with the other person's problem

Team-working is challenging. Interprofessional working implies a shared learning experience with, from and about each other and involves a reduction in professional autonomy.[21,22] Team tasks need to be clear, motivating and consistent with group purpose,[23] intrinsically interesting with meaningful and inherent rewards, and subject to shared concerns about quality, vision, outcomes and evaluation.[24] Team leadership involves focussing efforts towards a common goal and requires the maintenance of a balance between the task, the group and the individual.[25,26] Perhaps it is not surprising that general practitioners are better at team-working with the core group than the wider network.

Future prospects

Threats to general practice from commercial rivals, the challenge from specialist-led policlinics, and the shedding of provider roles by PCTs seem likely to change general practice even more than the 1990 contract did. Professionals now in the wider multidisciplinary network may find a more natural home in the core teams of general practice, and general practitioners may welcome them as assets in a competitive environment. One way to retain a high quality health visiting service, for example, may be to incorporate it into general practice. We may be about to see a quantum leap in multi-disciplinary working; those involved in it will have an interesting time.

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