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WORKING INTERRELATIONSHIPS IN THE PROVISION OF COMMUNITY HEALTH CARE
(MEDICINE, NURSING AND MEDICOSOCIAL WORK)

Report on a Working Group

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CONTENTS

	Page
1. Introduction	1
2. Background	1
3. The community health team	2
3.1 General	2
3.2 Factors affecting the functioning of the team	2
4. Education of health workers to serve in community health teams	4
4.1 Basic education	4
4.2 Postbasic and continuing education	4
5. Conclusions	5
 References	
Annex I: Studies on communication and collaboration between health professionals (physicians and nurses: teamwork) - Paper by Dr F.A. Boddy in collaboration with Dr M. Lorensen	7
Annex II: Opinions, feelings and perceptions of health personnel concerning their needs for continuing education: problems of interprofessional relationships. - Summary report of a study published by the Department of Health, Region of Tuscany, Italy	37
Annex III: List of participants	41

1. Introduction

The Working Group was convened by the WHO Regional Office for Europe at the invitation of the Italian Government, in collaboration with the Regional Government of Tuscany.

The purpose of the meeting was to obtain views of physicians, nurses and medicosocial workers on the subject, and:

- to discuss the situation with regard to working relationships and intercommunication among health professionals employed in teams currently established in Europe for the provision of community health care; and to examine factors assisting or inhibiting effective teamwork in community health services;
- to identify areas urgently requiring attention;
- to propose alternative courses of action which would assist in overcoming the identified problems;
- to prepare guidelines for the planning of educational programmes designed to promote team effectiveness.

In all, 19 participants attended the meeting as temporary advisers (see Annex III).

Participants were welcomed by Mr Giorgio Vestri, Minister of Social Security of the Region of Tuscany.

Dr Leo A. Kaprio, WHO Regional Director, was represented at the meeting by Dr R. Glyn Thomas, Regional Officer for the Development of Community Services.

In his opening address, Dr Glyn Thomas drew attention to a conclusion of a 1975 meeting in Reykjavik that "countries should establish and develop interdisciplinary primary health care teams of generalists, supported by a secondary level staff with relevant specialists from each of the disciplines comprising the team":¹ and to the observation in the Declaration of Alma-Ata that primary health care relies on "health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners, as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community".² In the European setting, the medicosocial worker is by implication included among such workers.

The overall aim is to make the delivery of health services more effective by collaboration and teamwork.

The role and function of each health team member, the composition of the team, assessment of the consumer's needs, awareness of one's own function and role, awareness of the place of communication within the team, and from the team to the individual and the family, and the team's relationships both within its own particular administrative structure and with other teams, are issues which need to be closely examined.

The contribution of the team in the community health care setting could be considered in relation to the regional programmes on primary health care, health care of the elderly, health manpower development and nursing/midwifery.

Miss M.-F. Collière was appointed as Chairman of the Group and Professor P. Paci as Vice-Chairman. Miss M.O. Abbott acted as Secretary and Dr Margarethe Lorensen as Rapporteur.

2. Background

The work of health service personnel in Europe has in the recent past shown a clear trend towards community health care, as health services in homes, factories, schools and other relevant non-hospital situations have become more extensive. This development has arisen in part from a need to seek alternatives to increasingly costly institutional care, in part from a better appreciation of the problem due to changes in both the demography and the morbidity of European populations and in part from a better understanding of the services required to meet the health needs of the community.

¹ The definition of parameters of efficiency of primary health care and the Role of nursing in primary health care: report on two Working Groups, Reykjavik, 1975, Copenhagen, WHO Regional Office for Europe, 1976 (ICP/SHS 039 and ICP/SHS 004), p. 25.

² Alma-Ata 1978: Primary health care. Geneva, World Health Organization, 1978.

It is now known that, in many health situations, individuals in the community do not necessarily require the services of a physician, but may stand in need of general support, care and help which can best be provided by the professional nurse and/or other members of the health team.

A significant product of this situation has been a growing trend towards the development of interdisciplinary teams and an increasing awareness of the importance of communication and collaboration among the different health disciplines concerned.

Studies on cooperation among health professionals initiated by the WHO Regional Office for Europe in 1977 (Annex I) have demonstrated that there is frequently a lack of knowledge and understanding of the function of the various team members, with consequent poor communication and limited collaboration. Furthermore, the laws governing health workers often hamper flexibility in teamwork.

3. The community health team

3.1 General

A great deal has been written about interdisciplinary teams, i.e., teams made up of a variety of health workers from several professions.¹ Not much has actually been done in terms of objective evaluation of factors which either help or hinder teamwork. However, studies have pointed to certain common problems and three main categories of factors affecting the functioning of a health team: (a) the health care system, (b) the administrative structure of the team and (c) its internal organization.

The Group's attention was drawn to what has been described as the nuclear primary care team comprising the physician, the nurse and the medicosocial worker,¹ and these were the disciplines represented in the meeting. It is recognized that there may be a variety of staff of other disciplines in a health team. The factors assisting and inhibiting the functioning of the team, whatever its composition, are nevertheless likely to be similar in nature.

The assumption underlying the provision of community health care by teams is that interprofessional collaboration is worthwhile in qualitative and economic terms, from the viewpoint of the consumer and of those collaborating in the health team.

3.2 Factors affecting the functioning of the team

(a) Health care system

There is a need to define the place and role of the community health team in relation to the total health care system, so that the team knows its role and function in that system.

The structure of the country's health/illness and welfare services and their relationships with each other and with other institutions will affect the team's work. The country's legislative framework and political policies will influence the distribution of human and material resources to the team, as well as the manner in which the team functions to meet the community's health needs. By the same token the laws governing the different health professions, as well as the methods of payment for the health services, can be a considerable constraint in the development of teamwork and the practice of team members.

The types of needs of the consumer, and the extent to which the team can meet these needs, are dependent on the society's cultural traditions, philosophies and values.

Human and material resources available to the team for services and education also depend on the economic resources. Priorities must be assessed and the share of the tax money to meet the demands of public services be weighed against other demands at local and national levels.

(b) Administrative organization of the team

The extent to which teams in community health care settings have developed in different countries has been dependent on a number of factors, so that there is no one single best or ideal model available for their organization. It can be said, however, that to be effective the team which delivers health care to the community should be suited to the setting in which it must work and that what the team can achieve will be subject to the limitations described under 3.2(a) above.

¹ WHO Regional Office for Europe. Trends in the development of primary care: Report on a Working Group, Moscow 1973. Copenhagen, 1973 (EURO 4309).

The aim of the team's service should be one of enabling the consumer to manage the situations which the individual/family faces and, as far as possible, to participate in decisions affecting his/the family's welfare. All team members should be actively involved in the identification and formulation of the team's goals which, it must be reiterated, should reflect the community's needs for health care. The team should have some degree of autonomy for effective functioning. It should be able to control or significantly influence the performance of its work and the availability and distribution of its resources.

A major influence in team functioning is its administrative structure. Differences in the conditions of employment and salary scales for different team members have implications for working relationships since, apart from any professional group affiliation, each member is affiliated to at least two groups: the team itself and the employing agency, which may be different for each member. While dual membership in these groupings need not be conflictive, difficulties in working relationships can arise. These may result in conflicts of accountability and definition and scope of duties of team members, all of which may be at odds with the priorities of the team.

(c) Internal organization of the team

Roles and functions of health workers have to be viewed in the context of changes in the society in which the individual lives, e.g., change in the status of women, rapid increase in technology and decrease in economic and natural resources.

The development of positive working relationships in the team requires a recognition of the need for some kind of equilibrium, for a balance between the need for leadership and the recognition, on a basis of mutual respect, of the essential contribution of each team member. Power struggles should be recognized and efforts be made to avoid them, each team member being accountable for his own actions in helping the team to function at its optimum level in achieving the established objectives.

Good communication between team members is crucial for team functioning. Effective teamwork may require as much as 20% more time than individual practice. Much of this time is taken up with communication between team members and consumers and between individual team members. The Group took the view that time for communication with the patient/client/family, as well as in interprofessional relations, is a legitimate part of the health professional's work and is one of his most important tasks with far-reaching effects both for the team members and for the community being served.

Team development requires time for education on teams in general and teamwork, and for application of the knowledge. Several participants expressed the view that teamwork should be learned preferably by actually working in a team or by observing a well-functioning team in action.

There is great need for evaluation both within the team and together with the consumer. Team members should appraise their own performance and have a clear understanding of their responsibility and accountability for their actions in the delivery of health services to clients.

Work within the team, while enhancing the contribution of the individual professions, also creates pressures for the modification of roles and for the adaptation of skills in directions which are likely to move people away from traditional perceptions of appropriate tasks. The consequence for each team member is the emphasis placed on the individual's self-confidence and the need to have a secure professional identity.

It was acknowledged that the maintenance of team relationships requires regular conferences attended by all team members. There is also a need for continuity and stability within the team and with clients. Introduction of new team members requires a special effort in terms of communication.

There should be a common record system (using language understandable to all), which should be centrally placed and be available to all team members. The matter of accessibility of the consumer to his records may need to be considered. Special attention should be paid to the storing, sharing and collecting of data on environmental problems and the needs of individuals and families for health care and social services.

4. Education of health workers to serve in community health teams

In making proposals for planning and implementing educational programmes, consideration needs to be given to patterns of health and social legislation, including decrees which extend beyond national boundaries, such as those being developed in the European Region.^{1, 2}

4.1 Basic education

One major problem which community health services face today is that basic education for the health disciplines in most of the European Region does not prepare professionals who are capable of providing the health or community-oriented care required to meet the current needs of the consumer.

Studies of the community's health needs indicate that social, cultural, psychological and economic needs are just as important as the physical ones. Educational programmes for most health workers are generally dominated by theory and practice concentrated on care of the acutely sick in the hospital, and provide little or no background for assessing or meeting the needs in other areas. If these health workers are to make a significant contribution to the care of families and consumers in the community, their education should be drastically changed.

There is a need for the basic education programmes in nursing, medicine and medicosocial work to produce generalist practitioners able to view each individual as a totality. The many medical specializations do in fact divide up the human body. There is a need in the disciplines to discuss and clarify concepts of wellness and illness, since different professions, and professions within themselves, do not have the same notion of these phenomena or of the contribution which other health sectors can make. People who are attracted to work in community health services are different from those who are attracted to, and obtain job satisfaction from, caring for the sick; and teachers need to be aware of this difference.

If, for example, learning experiences for nurses and physicians, and other categories of health workers, could be provided in the community early in the particular training programme, knowledge of the influence of environment, culture, value systems, and socioeconomic conditions on the lives of individuals, families and groups would greatly promote student awareness of human needs.

Encouraging experiences were reported of basic education programmes where social work students have joined students from one or several health disciplines in carrying out a research project. The main goals in using the research process as a learning tool are to help students to (a) develop an awareness of the consumer's and community's needs, (b) acquire the ability to establish a working interrelationship with other health professionals and a positive attitude to interpersonal relationships and group work, (c) develop greater self-awareness as part of their personal growth, as well as an adequate perception and understanding of their discrete roles, and (d) accumulate systematically a body of knowledge of the discipline on which to base individual professional practice.

4.2 Postbasic and continuing education

Opportunities for postbasic studies, in addition to in-service and continuing education for personnel providing services to the community, should be an integral part of all employment of health workers.

This training should help prepare the health worker to:

- use the research process in planning and evaluation of services in relation to the needs of the consumer and community;
- function in community health services;
- work effectively with other people; and
- unlearn skills and practices no longer useful in providing effective health care.

It was stressed that teachers responsible for such programmes need much better preparation. Wide cultural knowledge and thorough knowledge of the principles of adult education/learning, and of modern educational strategies and methodology, are required.

¹ European Communities. Council Directives 77/452/EEC and 77/453/EEC of 27 June 1977 and Council Decision 77/454/EEC of 27 June 1977 concerning nurses responsible for general care.

² European Communities. Council Directives, Decisions and Recommendations 75/362-369/EEC of 16 June 1975 concerning physicians.

The fact is that the licence to practise for most health workers is awarded once and for all, with no requirement for evidence, at specified intervals, of competence being maintained. All health workers in this decade of rapid increase in knowledge in all disciplines need life-long education if they are to keep abreast of knowledge in their field and maintain competence to practise.

The Group was informed about an experience in continuing education, aimed at analysing the main concerns of health workers in the district in order to give an understanding of socioprofessional interrelationships. The course was attended by 116 persons, all involved in health care delivery. The teaching was based on the method of small group discussion on such subjects as: the concept of health, and the health situation in the district; the contribution of different health services to the promotion of health; optimum use of human resources; improvement of interrelationships; development by health workers of a scheme of continuing education for themselves; and community participation in solving health problems. The innovative aspects of the course were the participation of different professions and groups; the presence of an interprofessional teaching team; and the setting up of a steering committee to develop, stimulate and improve interprofessional relationships.

It was clear that, while in many settings the provision of health services is still organized on traditional patterns, there is a lively awareness of the need to experiment and to change approaches.

Attention was drawn to a study on the views of health personnel concerning their needs for continuing education, carried out by the Region of Tuscany Department of Health (Annex II).

In conclusion, for individual team members to work together effectively, in a satisfying and creative environment, there is a need for:

- mutual agreement on goals and priorities for action;
- equality in status and personal interaction;
- a shared base of scientific and professional knowledge with complementary diversity in skills, expertise and practice;
- mutual trust and respect for each other as a person and each other's competence;
- maintenance of knowledge in one's field and competence to practise.

The Group considered that it is as yet too early to make a comprehensive appraisal of the impact that community health teams would have on health care systems since at present they are not yet a common feature of such systems in Europe. Nevertheless, it was convinced that working in teams should play an increasingly important role in the delivery of health care and that health workers generally should therefore be ready to function in a team setting.

5. Conclusions

The following conclusions were reached by the Group.

1. Working in teams to provide community health care represents a dramatic change in traditional universally accepted approaches, since it involves various patterns of health services and cuts across professional boundaries. This change is emerging as a response to many factors, such as conditions of life and culture, and health needs of individuals and families.
2. Health workers may be brought together in a variety of ways to function as a team; for example, they may be delegated by the central authority or by local authorities and communities, or they may be directly appointed by a central authority or by an individual interest group.
3. It is important for all members of the team to have freedom to exercise their particular skills and to perform their specific functions within the team. The individual contribution of each team member, which is provided by virtue of his or her special professional expertise, should not be taken over or supplemented by team members with different professional backgrounds.
4. It is desirable for the team members to develop a shared approach to the problems they encounter and to deploy the skills they have in common, as appropriate, to meet the needs of individuals and families, since it is implicit in the concept of team activity that team members should work together and help each other.
5. The relation between the team and the community should be marked by a common concern, e.g. the availability of services relevant to the community's needs. Thus the working hours of the team should be decided mutually on the basis of consultation of the community regarding its needs and

demands. Also, the team members should have knowledge of how to work with the community in defining priorities for action, the implications of such action, and ways of applying the existing human and material resources economically and effectively.

6. To help health workers to function in teams in the community, urgent attention should be given to the provision of appropriate education and training at both basic and postbasic levels and of programmes of continuing and in-service education.

7. Basic education programmes should be arranged in such a manner that students of various health fields, e.g. medicine, nursing, medicosocial work, apart from receiving instruction in their individual discipline, can take selected courses together, as well as courses with students of other disciplines.

8. Reference material and library resources, including access to journals and other learning materials, should be readily available in educational and service institutions for the respective disciplines and in shared fields of professional expertise.

9. Health workers should be encouraged to engage jointly in continuing education activities which should, among other things, prepare them for working in teams, research, teaching and counselling.

10. Thought should be given to the feasibility of requiring evidence of completion of continuing education programmes to be furnished at specified intervals by all licensed health workers as a precondition of renewal of the licence to practise. The form of such programmes, their content, duration, frequency, etc., will need to be carefully decided.

11. Education programmes at basic and postbasic/postgraduate levels should utilize a problem-solving approach for teaching and students should learn to apply this approach in planning, executing and evaluating their work.

12. To change the emphasis in teaching from illness to health, students should be introduced to learning experiences concerned with the problems of everyday life of healthy and sick individuals and families in the community, prior to gaining experience in the care of the sick in institutions.

13. It is desirable that existing legislation which hinders the practice of either team members or the team as a whole should be reviewed, and legislation which places restrictions on programme content should be amended.



Annex I

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STUDIES ON COMMUNICATION AND COLLABORATION
BETWEEN HEALTH PROFESSIONALS
(PHYSICIANS AND NURSES: TEAMWORK)

by

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in collaboration with

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The report presented is based on observations during visits to eight health centres in Denmark, Hungary, Netherlands, Sweden and the United Kingdom.

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Table of Contents

	Page
1. Introduction	1
2. Study methods	2
3. Place of teams within health care systems	3
4. Internal organization of teams	12
5. The individual within the team	17
6. Conclusions	19
Acknowledgements	20
References	22
ANNEX I Topic headings for discussions during visits to teams	
ANNEX II Main features of the report	

Studies on Communication and Collaboration
between Health Professionals (Physicians and Nurses: Teamwork)

1. Introduction

1.1 In the recent past, growing awareness of the potential of community health services has focused attention on the manner in which these services are organized and provided and the way in which they relate to each other. Such an interest arises in part from a need to seek alternatives to increasingly costly institutional care, in part from an appreciation of the problems due to changes in both the demography and the morbidity of European populations and in part from a better understanding of the potential of the services in meeting the health needs of the community. A significant aspect of this last development is an appreciation of the role of nursing and social work and of the way in which these professions may complement more traditional forms of primary medical care. The idea of the multiprofessional team as a form of organization which enables the three professions to enhance their individual contributions has gained growing acceptance in the past 15 years although its origins are much older (1). The extent to which team practice has developed in different countries has, of course, been dependent on a number of factors; nor can it be said that there is a single best model for the organization of teams and it is not desirable that there should be. There is, however, a substantial literature which reports on a variety of experiences in different settings and it was the purpose of this study to try to determine, in an exploratory way, whether it was possible to identify common features in these developments which would be of value in obtaining a better understanding of the value of teamwork and its effectiveness as a method of promoting more effective health care.

1.2 In the initial planning of the study it was necessary to adopt working definitions of the terms "team" and "teamwork" if only to provide a frame of reference for its design. Since the organization of most teams reflects the national and local patterns of health care in which they are located it also seemed important to employ statements that were independent of these modifying variables. The following definitions from WHO reports, as quoted by Hogarth⁽²⁾, were therefore used:

"Team: a non hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive health care practicable".

"Teamwork: a method of working towards a common goal which enables several persons to make the best use of their qualities by combining their skills and experience".

It is important to stress that it was not the purpose of the study to establish judgemental criteria of what did or did not constitute a team or teamwork and these statements are not employed in this way.

1.3 The objectives of the study were defined as describing patterns of professional interaction, mainly of nurses, physicians and social workers in their organizational context with a view to (a) identifying the factors that promote or impede the effectiveness of teams and groups in health care delivery; (b) developing a methodology for evaluating the effectiveness of teams and groups in health care delivery; (c) planning educational programmes designed to promote team or group effectiveness; and (d) identifying areas requiring research.

1.4 When considering possible approaches to the design of a study that would fulfil these objectives it was necessary to consider the forms of evaluation that would be appropriate and, in particular, the way in which effectiveness might be defined. In ideal circumstances, one would have wished to see measures of effectiveness expressed in terms of benefits to patients or clients or in terms of improvements to the health of the wider community. In practice, of course, this would have presented substantial methodological difficulties and would, in effect, have required an assessment of the benefits of community health care, per se.

As an alternative - though less than ideal - approach, it was assumed that the services of the professionals comprising the team were of benefit and an answer was sought to two questions concerning the effectiveness of the team as a form of organization. These were:

- (1) whether participation in a team enhances, facilitates or improves the contribution of its individual professional members; and
- (2) whether the team provides a more balanced and coherent form of health care to the client or to the community than would otherwise be the case.

In the event it proved difficult to provide answers to these questions in any direct, objective sense due to the multiplicity of factors influencing the complex social interactions implicit in team relationships. Nonetheless, the questions were relevant as a guide to the orientation of the study and as a reminder that it is in these terms that the validity of the team as a form of health care must eventually be judged.

1.5 A final introductory comment is that in a brief study of this kind one's evidence is inevitably incomplete and one's judgements to some degree subjective. In acknowledging the likelihood of bias in the discussion that follows the comment of Charles Darwin, quoted by Micks⁽³⁾ may be apposite:

"How odd... that anyone should not see that all observations must be for or against some view".

2. Study methods

2.1 The methods used in the study were largely determined by its exploratory nature and by constraints of time and resources. In the planning stages it was possible to identify a fairly large range of topics likely to be pertinent to the practice of particular teams and to the degree of collaboration achieved by the different professional members of the teams. In developing this approach further, it became clear that the issues could be regarded as falling into four broad groups:

- (1) factors having to do with health care planning and the level of resource provision for community care; relationships with other institutions or organizations which may have relevance to the health status of the client; the team's identification of its goals in the context of the needs of the community;
- (2) organizational and administrative influences on the constitution of the team and on its members, and including legal constraints, the status of team members, and administrative requirements for performance of tasks and the manner of working; other factors such as resource provision and the location of the team in the context of the larger health care system;
- (3) internal organization of the team; its constitution and the nature of the inter-disciplinary relationships; identification of goals and establishment of priorities; sharing of information and nature of the record systems; support facilities and their management;
- (4) education for teamwork; preparation for work in this setting and opportunities for appropriate continuing education; skill development; professional self-perception and orientation and external influences on these factors.

2.2 Practical considerations limited the extent of the field investigations that were possible and so it seemed sensible to formulate a number of subject headings within the four groups of issues and to explore their practical significance in the course of visits to a small number of selected centres. The protocol in the Annex was drawn up as the framework for discussions during the visits. The latter were not seen as formal data-gathering exercises, however, and the questions posed in the Annex should not be interpreted as a questionnaire in which specific answers were sought. The visits were necessarily of short duration and were intended to provide an opportunity for the discussion of the particular centre's experience of teamwork and the problems it had encountered. Although the discussions were structured around the questions, they were necessarily of an informal nature, the objective being firstly to allow people to express their own view of an issue and secondly to determine whether the topics identified in the protocol were of consequence in practice. Because of the method used, of course, the data collected during the study, and the conclusions drawn from them, cannot be regarded as formal research findings.

In the discussion which follows, it is important to keep this proviso in mind and to interpret the arguments that are put forward as a preliminary analysis of a complex situation in which any single factor is likely to influence - and be influenced by - any other factor.

2.3 Had resources permitted, it would have been possible to select a fairly large number of centres in a range of countries in which interdisciplinary teams of various kinds have developed. In the event, the eight centres that were visited were chosen on the grounds of their being likely to demonstrate features of teamwork relevant to the purposes of the study; the main criterion was simply that the centres were likely to have a sufficient experience of professional collaboration to contribute usefully to a discussion of the topics identified in the planning stage. They were not chosen on the grounds of their being typical of the community health services of the five countries (indeed, several are not typical). Nor do the centres comprise a formal sample of health care teams.

2.4 It is also important to stress that the study was not concerned with direct comparisons between the participating centres or with judgemental assessments of the extent to which the staff of a particular centre did or did not constitute a team. Each centre has evolved in its own context and with a background of different influences on the provision of community health care.

2.5 The eight participating centres, which were visited for one or two days each, were:

- Centre of the Social and Health Administration, Roskilde Kommune, Denmark
- 13th District Council Polyclinic, Budapest, Hungary
- 18th District Council General Practice Centre, Budapest, Hungary
- Feijenoord Health Centre, Rotterdam, Netherlands
- Ommoord Health Centre, Rotterdam, Netherlands
- Dalby Health Centre, Lund, Sweden
- Kentish Town Health Centre, London, United Kingdom
- Woodside Health Centre, Glasgow, United Kingdom

Considerable help and cooperation were offered by the many people who took part in the discussions at the centres. The study involved asking many detailed and probing questions about the organization of the centre and about working relationships and attitudes. All those concerned cooperated in a frank and open way that did a great deal to show the characteristics of different centres and to permit distinctions to be made between aspects of team relationships that are general and those that relate to local circumstances.

3. Place of teams within health care systems

3.1 Before discussing specific aspects of team practice and the issues that appeared to be significant to the centres, it is necessary to consider how each functions within the overall national health care system. These are important considerations because the concept of team care in a particular health care system depends on the way in which the role of general practitioners, nurses and social workers is perceived, on the way in which health care in the community is defined and on the problems and priorities that are recognized. Team care is simply one model for the organization of community health services and whether or not it is considered appropriate depends on appreciation of the benefits it provides when applied in a particular context and tradition of health care. This being so, it is scarcely surprising that the various centres exhibited a range of features that reflected both the substantial influence of external factors (for example, the different modes of employment of team members) and the more local concerns and responses of the team members themselves.

3.2 Broadly it was possible to distinguish four different approaches to interdisciplinary collaboration which derived from the overall organization of health and social services.

The two centres in the United Kingdom and the two in Rotterdam have teams patterned on the group practices of the physicians as well as the populations served by these practices. In Denmark, the stimulus for team organization (although still in a stage of early development) came from the social and health administration of the town of Roskilde and the general practitioner occupied a much less central position in the evolution of team care. At Dalby, a rural area near Lund in Sweden, the health centre is closely linked to the Department of Internal Medicine of the University of Lund and thus to a substantial programme of clinical and laboratory research; the pattern here is of close working together of different services which still retain a separate identity. Lastly, in the closely integrated and well-defined progressive health care system of Hungary, demonstrated by the two centres in Budapest, the general practitioner and community nurse form part of a system, which has implications for both their individual roles and the relationship between them.

3.3 The health centres in the United Kingdom are purpose-built institutions offering a range of services to large inner city populations. Woodside is served by eight group practices which vary in size, the general pattern comprising three to four physicians, two health visitors, two community nurses and the services of one social worker who may be shared between teams. Each group serves about 8000-10 000 patients. At Kentish Town there are two larger practices (with six physicians in each) and, again, these constitute the basic organization. In addition to community nurses, there are practice nurses (a) who undertake a range of practical activities and to whom patients have direct access for counselling and advice on a variety of problems. In both centres the level of social work is fairly low so that, while differing opinions were expressed, it could be argued that the full potential of collaboration with social workers has not been realized.

3.4 In each centre it was possible to identify a number of organizational features relevant to the character and functioning of the multidisciplinary teams. The members of each profession are in fact, members of at least two groups: the team itself and different professional groupings which to a greater or lesser extent also function as teams. At Woodside, for example, the nurses work within the hierarchy of nursing management and are accountable to a nursing officer responsible for the coordination of nursing services throughout the centre. Although such dual membership does not necessarily cause overt conflict, it does create a dual loyalty and can bring problems for the nurse in terms of the way she perceives her primary affiliation. This difficulty may be accentuated by the nature of the physician's practice, his own mode of employment and the financial arrangements of the team, all of which emphasize the fact both the nurse and the social worker are attached to the practice and are less permanent members of the team or have a lesser commitment to it. Problems of this nature are further accentuated by the structure of the British National Health Service and the separately administered social service departments of the local government authorities. Although health centres are now quite common in the United Kingdom, they exist as facilitating institutions in which practice-based primary care teams and related services can be accommodated. One consequence of this situation is that it is difficult to speak of the health centre as an organizational entity able to determine its own priorities and evolve a pattern of work from which common team objectives could emerge. At present, the team members are constrained in their relationships by the three quite different organizational or management structures to which they relate.

3.5 The conflict between the needs of the team on the one hand and the requirements of the larger system on the other was a recurring theme during the visits. The nub of the problem in the two United Kingdom centres - and also in the Netherlands (see paras. 3.8-3.10) - is that the team as such has no formal identity and no clear structural relationship within the larger management system. This lack of identity creates a number of problems that interact in inhibiting team development: these include difficulties in financing services and meeting the costs of teamwork; the problem of dual loyalty, status and commitment within the team and the more complex question of the extent to which a team can, on the one hand, be autonomous and accountable principally to the population it serves or, on the other hand reflect the needs and priorities of the larger system and be more explicitly accountable to it.

(a) Practice nurse: a nurse who is employed by a group of physicians working together in general practice and working only within the physicians' premises.

3.6 The acceptance of these arguments depends on a number of factors: one's view of the objectives of team practice; status differences between the professions and the relationships between them that are desirable; and the extent to which the multiprofessional team can be envisaged as a unit for community health care provision. One can, for example, put forward the contrary argument that the relationship between the general practitioner and his population of patients is important in a number of ways for both physician and patient and that to compromise the distinct role - or place in the system - of the physician, nurse and social worker by blurring the organizational differences between them may have penalties as well as benefits for both the professional and the client. On the present evidence, it is difficult to substantiate either viewpoint; much of the literature (3) in this area is subjective in the sense that it reports particular experiences and thus reflects the attitudes and assumptions of those involved. One conclusion of the visits to the centres in the United Kingdom and in the Netherlands, however, is simply that the capacity of a multidisciplinary group to develop effective internal relationships depends on the external professional and administrative relationships of its members and on the importance that the team concept has in the larger management structure.

3.7 Problems of this nature were reported in both the Kentish Town and Woodside centres - although they were perceived more acutely at Woodside, possibly because the larger practices in Kentish Town resulted in larger, more self-contained groups with a rather different perception of the role and nature of the team. They appeared to be of even greater significance in the Rotterdam centres partly because both had more explicit goals for the development of their teams and partly because a different administrative and financial structure made the problems more acute.

3.8 The Ommoord centre is situated in a suburb of Rotterdam with a population of about 28 000 people, 18 000 of these being patients of the seven general practitioners in the centre which also has six community nurses, three social workers, two midwives and four physiotherapists. This group of 22 professional workers is divided to form two nuclear teams but the whole group, with the inclusion of clerical and other staff form the health care team of the centre and have tried from its inception about 12 years ago to evolve a pattern of collective organization and collaboration; in terms of the definitions quoted earlier this centre demonstrated the most advanced form of teamwork of those that were visited so that its organizational history is of particular interest.

3.9 In the Netherlands, the great majority of general practitioners are in single-handed practice and receive their income and practice expenses either from an annual capitation fee or from fees charged to the patient. Community nurses are employed by Cross Organizations which are autonomous charitable bodies supported by public funding; social workers are employed by a third organization and physiotherapists and midwives, like the general medical practitioners are in independent practice. Against this background, the formation of a health care team presents a number of problems: there is, first, the simple one of the provision of appropriate facilities, in the proper physical relationship, for the various members of the team; there are the organizational problems of dual loyalty noted above in establishing a working environment for the team which includes achieving a proper balance of team members, and there are the problems of financing the collective needs of the team and of developing its activities.

3.10 Clearly, a great deal has been achieved by the group at Ommoord (4) and many difficulties have been overcome. Because it is seen as an experiment, the team has received support from external sources and it might also be argued that the group's determination to achieve a high level of team collaboration has created difficulties that might not have been encountered elsewhere - as demonstrated, for example, by a general practitioner's comment that effective teamwork requires about 20% more time than ordinary practice. The development have, in turn, led to financial problems deriving in part from this changed pattern of work and in part from the general practitioner's having to subsidize the additional costs of team practice. Interim solutions - including the general practitioners and other independent members of the centre's staff becoming employees of the city of Rotterdam - have, in the centre's view, failed to overcome these difficulties; the external constraint of the tripartite relationship between the three employing agencies continues to create internal stresses within the team which therefore feels to some degree that it is unable to develop in the way it would wish.

3.11 The health centre at Feijenoord is situated in an old district of Rotterdam in the same building as an active community centre which provides a range of social and educational facilities for the population of this relatively deprived neighbourhood.

One feature of the population is a high proportion of immigrant workers from southern Mediterranean countries and Turkey. Although the health centre is formally a separate entity, the health professionals working there have a broader commitment to the development of the community and are concerned with the larger problems it encounters. In organizational terms, the seven general practitioners continue to have independent practices (while working collaboratively as a group) and relate directly to the five nurses and four social workers who are also based in the centre. A feature of social work in the Netherlands is the distinction that is made between material problems and problems concerning personal relationships or of a psychosocial nature. The social workers who relate to health care teams are concerned more specifically with this latter area and, as elsewhere, the health centre has developed this feature of social work in the direction of group activities of various kinds in which both physicians and nurses are also involved. An additional feature of the centre (which also reflects its community orientation) has been the inclusion of a dietician as a member of the team. While interesting as a specific development, this point also illustrates two general features of the evolution of teams visited in the United Kingdom and the Netherlands; these are, firstly, the open-ended nature of health care in the community and, secondly, a similar lack of precise definition of the concept of teamwork. The nature of team, and the activities in which it engages are, at the same time, a reflection of the way it perceives the problems of the community and of the resources available to it. At Feijenoord the presence of a fairly large number of old people and non-European immigrants in the population has influenced the priorities and the nature of the services; these features and the particular resources of the centre have combined to create a pragmatic approach to interdisciplinary relationships and team development.

3.12 All four of the centres so far discussed are examples of team development on the medical practice model and each, to a greater or lesser degree, raises issues in the provision of health care in the community which go beyond those of team care. In other words, one can argue that the further evolution of team care in the context of this model will depend on more fundamental changes in the organization of community care. Such changes involve a number of complex issues which go beyond the scope of this paper but it is important to note the importance of a clearer definition of the role of primary care within the larger health care system as a prerequisite for the further growth of the team.

3.13 At the level of the team, there are at present a number of uncertainties and ambiguities that make changes necessary; in organizational terms, it is perhaps possible to reduce these to three main issues. These are: firstly, the relationship of individual team members to external organizations or agencies which influence and to some extent control the fulfilment of their professional role; secondly, the needs of the team as an organization and its capacity to evolve as a coherent group and to define its priorities in relation to its client population; and thirdly, an issue deriving from the first two, acknowledgment of the team as an entity within the formal structure of health service management and thus recognition of its status in the planning and provision of community services.

3.14 Problems relating to each of these three basic and interrelated issues were noted in all four of the centres visited in the United Kingdom and the Netherlands. Difficulties in role fulfilment and the - often indirect - control exercised by different employing authorities have been noted above in references to the question of dual loyalty and, in one instance at least, were also evident in more specific administrative definition of the role and priorities of the nurse. The method of payment of physicians emphasises their commitment to their practice, as compared with the involvement of other team members, and makes an important contribution to their dominance of the team and the priorities it establishes. It would be unjust to leave the impression that this dominance is all-important; in different ways, each of the four centres are making serious and honest attempts to develop a genuinely egalitarian approach to collaboration within their teams. The point to be emphasized is that the external conditions for teamwork are such as to make the criteria set out in para. 1.2 very difficult to satisfy.

3.15 An important feature of the difficulties in the existing situation was the ambiguity of the team, as a unit of community health care, in its relationships to the management of health and social services. This lack of status, or of a formal position in the management structure, creates an inherent conflict in the development of the team which, by definition, seeks to adopt a new approach to the delivery of services and to grow in response to its recognition of the needs of its clients and its professional assessment of the services that are appropriate to these needs.

In other words, a professionally derived concept of teamwork carries with it the implication that the team will have at least a degree of autonomy; such autonomy would include control or significant influence over the resources available to the team and it also implies the ability to relate to the wider management structure in discussing ways in which the team might develop in the future and the resources that it will have available. While it appeared that the management relating to the four centres were in general sympathetic to the expressed needs of the teams concerned, it was also evident that difficulties of this nature were also the source of frustration and uncertainty. One consequence of this situation is a conservative reinforcement of the practice as the effective unit of primary health care and inhibition of the growth of the team. Without a resolution of issues of this nature it would seem to be difficult to go beyond the stage of interdisciplinary association in the development of teamwork.

3.16 Although not directly relevant to the team, as such, it may be worth noting that a further consequence of the difficulties in recognition of the team as a unit of health care is emphasis of the medical model of services in the provision of health care. Nevertheless the teams visited, especially in the Netherlands, were seeking to break away from this model and to develop other approaches to the problems they identified.

3.17 The remaining four centres visited differ from the four already discussed and from each other; nonetheless, many of the issues that apply to the practice model of the team also apply in these other situations. One must repeat the point made earlier that teamwork reflects the status of particular professions and the roles that they fulfil in the provision of health care in the community; generalizations concerning the organizational context of a team may hold good in different situations but their significance varies according to the purposes of the team and its result.

3.18 The centre of the Social and Health Administration of Roskilde Kommune in Denmark differs from the other centres in that it is organized as a local government department with responsibility for a wide range of social and welfare services for a community of about 50 000. Both social work and community nursing services are a part of the organization which, under recent legislation, has a substantial degree of autonomy and is closely linked to the political administration of the Kommune. The degree of liaison is such as to permit a flexible and direct approach to the planning and delivery of services to a relatively small population. The general practitioners of the town continue in independent practice but liaison between specific social work and nursing teams and the general practitioners means that there is direct communication between individuals. One contrast with the other centres is that the emphasis in Roskilde is on the development of supportive services in the community in which the social worker and the nurse have a fairly substantial role and the general practitioners a much less central position. Another feature of the Administration is the relationship between nurses and social workers and more specialized support workers such as occupational therapists and physiotherapists.

3.19 The interest of this form of organization is the contrast it provides with those already described. For a population appropriate for team development, it provides an example of formal links between the community (represented by its politicians), the professional administration of both local and national services (a) and the professionals responsible for the recognition of needs and the delivery of services. There is therefore a clearer definition of the goals of service provision and greater opportunity for communication and feedback. More generally, this allows a closer relationship between policy, the planning and organization of services and the needs and priorities of the service providers than is possible in management systems concerned with services for larger populations and with more complex forms of administration.

3.20 Two further aspects of this model are that it is essentially one of social care and that, in terms of the development of team relationships, its closeness to the formal administrative structure may mean that the growth of interdisciplinary collaboration is modified or inhibited by the needs of the larger system. In practice there was little evidence that such inhibition is a real problem and relationships between the different professions appear to be good; this said, however, there are also inherent difficulties in the further development of teamwork in the sense of the definition in para. 1.2 and its emphasis on the combining of skills and experience.

3.21 The independent position of the general practitioner (strengthened by the financial arrangements of his practice) creates obvious difficulties of close collaboration, also taking into account the clearly defined responsibilities of the administration.

(a) The decentralization of administration extends to parts of the social security system which permits, for example, the integration of different aspects of social care for the disabled or elderly.

Apart from problems of communication at a fairly simple level, the model that is developing at Roskilde also has the effect of reinforcing the separate roles of each profession and may thus have the effect of restricting or inhibiting the evolution of a common approach to the client needs with which they are concerned. In the longer term, therefore, this may be a rather conservative form of organization satisfactory in terms of needs appropriate to the role perceptions of the professions involved but allowing little opportunity for the development of alternative forms of shared care in which particular professional roles are less important than the skills that are shared within the team. One point worth closer consideration is the role of the nurse in a social model of this kind. The separateness of the physician's position means that both he and the social worker are referring - or having referred to them - patients whose needs are seen as relevant to both professions. In addition, both may refer patients to the nurse. A consequence of these arrangements is that, for both professions, the nurse may come to be seen as someone who supplies practical skills; she becomes, in effect, a subsidiary member of the team and thus has difficulty in developing her own professional role. An objective assessment of this problem is difficult because the role of the nurse varies widely in Europe and it may be that the arrangements observed in Roskilde are as much determined by the status of the community nurse in Denmark as by a particular administrative arrangement. Whichever reason comes first, however, it would appear that within the general separation of functions inherent in this approach, the nurse is in a particularly constrained situation. The referral system, however, does not apply to the well-baby nurse as she gets the notification of all newborn babies from the Social and Health Administration Office.

3.22 The centre at Dalby has developed primarily as a unit for research and education in community health care, closely related to the Department of Internal Medicine of the University of Lund. The centre provides services for a rural population of about 20 000 and brings together the services of general practitioners, social workers and community nurses in addition to a number of more specialized services also related to research activities (5). One particular feature of the centre is that it has pioneered the development of a team of specialized nurses with a high degree of clinical expertise in the management of diabetes, hypertension and psychiatric disorders (6.7).

3.23 Like that at Roskilde, the Dalby centre fits less clearly into the specific team model seen, for example, at the Ommoord centre; in simple terms it is rather more an arrangement for the collaboration of services with well-defined roles, although the location of these services within one building and the coordination required by the research and development functions of the centre bring closer relationships and a clearer definition of the pattern of services for the population served. One aspect of this separation of services has been the opportunity to develop the role of the nurse who, within a defined area of expertise, is able to exercise considerable independence in the clinical care of patients; there has been a parallel growth in the case of the geographically-based community nurses who are also in a position to develop their own approaches to the nursing care in the smaller communities in which they practice. There are, of course, different views about the appropriateness of specialization of this kind by nurses and it is possible, too, to raise complex questions concerning "doctor-substitution" and the "proper" content of nursing practice. The point of general interest in an assessment of team development, however, is the extent to which an open approach to the nursing role, combined with a relative separation of services, permits the growth of the nursing contribution and avoids an external definition of what are or are not appropriate activities for the nurse in the community. The limitations of the study did not permit a detailed comparison of the work content of the community nurses in Roskilde and Dalby but, at a superficial level, the contrast was striking and would merit a more detailed comparative analysis.

3.24 The centre at Dalby also illustrates another difficulty in assessing and interpreting the evolution of teamwork in different centres and in distinguishing between perceptions of the role of a particular profession and the more collective remit of the team. At Dalby, there was an evident lack of close cooperation in terms of the relationship between individuals - although members of all three professions expressed a desire for better collaboration and for more of a team approach. The point may be that the recognition of common needs and difficulties that is a prior requirement of team development includes a mutual acknowledgement of the differentiation of professional skills and the ways that they can be employed in a complementary rather than a separate way. That this process can be helped or hindered by organizational factors external to the team is illustrated again by the separate nature of social work services at Dalby and by the way in which the administrative relationships inhibit closer collaboration.

3.25 In the Netherlands, and to a lesser extent the United Kingdom, the social work members of health care teams are primarily concerned with counselling and problems of psychosocial maladjustment and are not closely involved with matters relating to material problems and the functioning of the social security system in a way that requires them to be accountable to the system as well as to their client.

Social workers in Sweden do have such an accountable relationship and are, in addition, legally constrained in their approaches, for example, to alcoholism and the care of children. From the standpoint of interdisciplinary collaboration, these requirements inhibit relationships in a number of ways: firstly, the social work administration, in its remit, is required to make an administrative definition of the role of the social worker that may make full participation in teamwork difficult; secondly, the accountability relationship with the social security system creates problems in the sharing of information and the willingness of the physician or nurse to disclose confidential information; and thirdly, the legal position of the social worker may bring his objectives into conflict, if only potentially, with the therapeutic goals of the physician or the nurse - as, for example, in the case of the physician's management of the problems of a mother and the social worker's duty with regard to her children.

3.26 There are two further features of the Dalby centre which have significance for the development of the team as an organizational model for the provision of community health care; these are the relationship of the centre to a defined community and the availability of measures of need in that community. The requirements for autonomy of a team, mentioned earlier, include the establishment of such measures of need as a part of the process of defining the nature and concerns of the team. The relationship of Dalby to a larger academic facility places it in a favourable position for both satisfying this requirement, in a range of clinical and other disciplines, and providing an opportunity for evaluating new services and supporting the skills of the primary team. One could not, of course, expect that all teams could have support of this kind but the general point of the need to support the team with information about its work and the environment of its practice was well illustrated in this centre.

3.27 The above comment concerning support is an extension of those made earlier (paras 3.6 and 3.15) about the problem of the status of the team in the larger management structure, in that it provides an example of the positive approach that larger organizations may have to adopt in encouraging the growth of teamwork. The less precise question of the relationship of the team to its community is also illustrated at Dalby by the way in which the centre has developed in partnership with the local community, which was responsible for the provision of capital resources and which has facilitated its growth in other ways. There are parallels here with the developments observed at Roskilde and, less formally, with the community links which the two centres in the Netherlands are seeking to develop. The two Scandinavian centres are, of course, located in much less complex organizational settings than the Dutch and United Kingdom centres which have to relate to the administrations of large cities and so it is difficult to generalize without oversimplifying difficult questions of social administration. The whole matter of the relationship of the team, as a group of professionals, to the community it serves, including such issues as the nature of its "contract" with the community and the ways the team is accountable to it, is central to the concept of teamwork as a way of providing health services and is an area needing more detailed study.

3.28 The professional and organizational philosophy of the Hungarian health services, as illustrated by those of the 13th and 18th District Councils of Budapest, is in clear contrast with that of the other centres in the study and is important for this reason. The essential difference is that the local community services provided by the general practitioners and nurses form part of a highly structured system of "progressive health care" in which a patient is managed at a level appropriate to his illness and its therapeutic requirements. For both physicians and nurses, therefore, the concept of the team implies involvement both with a local grouping in the context of a health centre or general practice clinic and with a much larger grouping based on a district polyclinic which provides the first line of specialist services. Social services are organized on a separate basis although at comparable levels to those of primary health care and with the opportunity for close collaboration between the two services. The role and duties of both nurses and general practitioners within this system are precisely defined with the latter working in groups of six or eight, one of whom acts in a senior supervisory capacity and provides a formal link with the polyclinic hierarchy. Community nursing is organized in a similar way so that one physician and one nurse work closely together in geographically defined practices of about 2500 people.

3.29 Before commenting on specific features of this approach and their relevance to the concept of team care, it is necessary to draw attention to other aspects of the organization of health care in Hungary and to the assumptions of the larger system of which community care forms only a part.

Firstly, the description of the general practitioner in the previous paragraph is highly synoptic; in contrast with the generalist role of the physicians in the other centres, the Hungarian general practitioner is more restricted in his practice and is less likely to involve himself in such fields as surgery or gynaecology where the patient may either consult a specialist directly or be referred at an early stage of seeking help. Similarly, there is a separate service for the care of children and there are additional specialist services close to the community (for example, mental health) which have the effect of defining the scope of the general practitioner's work in a much more specific way than is the case of the general practitioners in the other settings included in the study. A consequence of these health care arrangements is that the role of the individual professional becomes one of serving the needs of the larger system of care and it is within this larger pattern of services that the health care team functions for a fairly large population. A second feature of progressive health care in Hungary is the relationship of the large district grouping to more complex technology and to more specialized services. It is an assumption of this highly planned system that the treatment of an individual will take place at that level of the system most appropriate to his condition, whether this is a local health centre or a clinic or a specialized national institute; what follows from this is a fairly precise differentiation of activities appropriate at different levels of the system with the roles of individuals being determined by the function of the particular setting in which they work.

3.30 Yet another important contrast between the Hungarian model and those seen in other centres is that, at each level, it includes provision for explicit accountability which combines oversight of the general work content of the professional with ongoing assessment of the care of the patient and the appropriateness of the level within the system at which that care is delivered. For the general practitioner this system of controls includes a periodic assessment of his work but also certain policies or rules of practice - as, for example, the policy that a patient's absence from work through sickness for a period of more than six days is reviewed by the supervising member of the group of six general practitioners and that sickness absence of more than 28 days' duration is reviewed at a specialist level in the polyclinic.

3.31 The accountability described above is an integral part of the system and applies to the work of nurses as well as that of physicians; its philosophy, in terms of the assumptions set out in para. 3.29, may be difficult to relate to the philosophy of free-standing professionalism underlying the arguments about the nature of the team that have been put forward in the discussion of the other six centres in the study. It is difficult to arrive at firm conclusions on the basis of a short visit but two impressions should be recorded: the first is that formal accounts of the organization of the Hungarian system may be misleading in suggesting that it is more rigid and dogmatic than is the case in practice; the second concerns the system of accountability where the use of the word "control", translated from Hungarian, may have connotations in other settings not implicit in the activities carried out in the Hungarian setting. There is indeed a method for control of the work of physicians and nurses but, unless one also takes account of an underlying difference in the nature of the professional functions and their relationship to the health care system, one cannot fully understand the purposes of this control and its influence on the functioning of the system. While the method may differ, for example, from the techniques of medical audit now evolving in the United States, the actual implications for the individual may not be too different.

3.32 Any attempt to contrast the pattern of teamwork observed in the two districts of Budapest with that of the other centres in the study is inevitably confounded by the differences in basic assumptions between the Hungarian system and those of the four other countries. At a simple level one can note the clearly defined role of the physician and nurse within the larger, more complex team and, consequently, the absence of ambiguity about the scope and content of community health care commented on earlier. Against this, it is necessary to set limitations with regard to the professional independence and the imposition of external criteria as to what the scope and content of community health care should be and the ways it is to be fulfilled. If one takes the view that a benefit of teamwork is greater flexibility in adapting the provision of care to the needs of clients, and a degree of autonomy in the way in which the team identifies its priorities then it could well be that the pattern of service provision in Budapest is inherently conservative simply because of its complexity and the need to define the tasks that individuals will perform in quite precise terms.

It is certainly a system that emphasizes the medical model (cf. paras 3.12 et seq.). But in making this comment it is again important to view the team and its evolution in the context of the larger system and its priorities; Hungary has made substantial progress in improving health in the past three decades (8,9) but the priorities of the system of health care provision and thus the manner of its organization are not those of countries in which the medical model of care is giving way to a more socially oriented approach to the planning of services.

3.33 It will be clear from this account of the external or organizational contexts of the centres visited that it is difficult to draw general conclusions about the evolution of the team as a model for providing community health care other than to say that such contexts are of overriding importance in determining the nature of the team and the way it perceives its tasks. Although not all of the points noted are relevant in all cases, there are perhaps three features which are of particular significance: dual loyalty; the professional status of the individual team member in the wider society; and the relationship of the team to the management structure of the larger health care system.

3.34 Dual loyalty refers to role conflicts which may take various forms and which are also of significance to the internal organization of the team. The problem can include differences in the manner of employment of different team members, conflicts in the definition and scope of the duties of team members as the team sees them and the external imposition (either statutory or administrative) of other tasks which may be at odds with the priorities of the team. There may also be a conflict of accountability - to the team on the one hand and to another organization or to a hierarchical superior on the other. From the viewpoint of team development, the effect of such conflicts is to inhibit the team's capacity for evolving its own priorities and for developing skills and activities in the context of the needs that the professional members of the team identify in their practice. This is likely to be of particular significance when the team seeks to move away from customary professional roles and to cross traditional boundaries.

3.35 The professional status of the different workers making up the team also has its effect in a number of ways. For instance, the answer to the question "what is nursing" has important implications for the nurse's status within the team and the role that nursing can play. There are of course more complex aspects to this question, including the legal standing of the different professions, the degree to which the professional nature of the skills is acknowledged and protected and the degree to which educational background, for example, permits individual members to play an equal part in the concerns of the team and to take professional advantage of the opportunities it offers.

3.36 Problems deriving from the relationship of the team to the larger management structure include those noted in the previous two paragraphs. A further problem of equal significance to development of the team model of community care is the constitutional status of the team in the formal management structure and thus its ability to deal with the superior levels of the structure as an acknowledged entity and not simply as an ad hoc grouping of professionals. This problem leads on to the question of the extent to which it is possible to regard the team as the primary unit of community health care and thus to complex questions concerning the organization and administration of community health services. At the least, it is difficult to escape the conclusion that the teamwork model of health care cannot be easily separated from the wider system of community care and that this model has implications for other aspects of policy if its adoption is to be successful. Some of these implications have been mentioned in the discussion on the eight centres visited: one is that of the relationship of the team to the community it serves and the relationship between needs and services; another is the accountability of the team both to the community and to the management structure. More specifically, reference has also been made to (i) the team's own needs for support facilities of various kinds, including the need for information concerning the conditions of its practice and for the provision of appropriate physical facilities, technical equipment and services and (ii) the nature of the team's relationships with more specialized services of all kinds and all of the participating professions.

3.37 One function of teamwork that was identified in the planning of the study but appeared to have little application in practice, although recognized by team members, is that of providing feedback to the larger system about the nature of the client problems encountered and the implications of larger scale policies for the solution of these problems.

The argument here is that the members of the team are in a position to observe the grassroots applications of policy and that they should therefore perform a "signalling" function in feeding back information of this nature to the policy-makers (10). The problem of course lies in finding ways in which this activity can be developed in an organized or coherent way, and this is thus another illustration of the larger issue of the relationship of the team to the management structure. If one accepts the argument that the larger system should provide support for the team, feedback provides an example of the converse process of the team's role in making the system responsive to the needs of the client and aware of the effectiveness of its policies.

3.38 This section has described certain characteristics of the eight centres visited as they appear to illustrate topics of relevance to the study; in doing so, considerations of space have made it necessary to neglect some aspects of the centres' organization and practice and to focus primarily on the team and its external relationships. The next section discusses the internal working of the team and considers particular features of interprofessional collaboration against this background.

4. Internal organization of teams

4.1 The diversity of membership of the teams visited makes it difficult to generalize about their internal organization; it would be naive, in any case, to suppose that there could be an optimum form of organization. It is possible, however, to consider three issues which provide a basis for assessing the functioning of the team and the factors that may influence its success in terms of the definitions in para. 1.2. These three issues are: firstly, the definition of the purposes of the team and the extent to which it provides a satisfactory setting for the activities of its members; secondly, the organization of the team and the provision of an appropriate environment for different professional contributions; and, thirdly, the internal administration and management of the team and the way in which necessary group relationships are developed and maintained.

4.2 With regard to the first issue, definition of the purposes of the team raises a number of more specific questions as well, once again, as the problem of autonomy and the external relationships necessary to encourage the development of a coherent identity for the team and a shared appreciation of its tasks. While these external conditions appear to be necessary or at least desirable requirements for teamwork as it has been defined, there are in addition internal matters of equal relevance, including the social organization of the team and the conduct of its affairs; problems of status differences between the professions and the way these are identified and overcome; and the acknowledgement of different skills and the capacity to adapt patterns of work in a way that takes advantage of them. In more general terms, there is a need to seek common ground between the participating professions and to identify shared concerns as a means of reinforcing the identity of the team. In the simplest terms, these factors on the one hand relate to the ability of individuals to appreciate the ways that team membership may be of benefit to them and on the other hand to their understanding of what it is they must contribute to achieve these benefits.

4.3 The second issue of the organizational features which influence the internal working of the team parallels that of the purposes and setting of the team described above. The provision of facilities and equipment including appropriate physical accommodation are obviously important both for relationships between people and for the capacity of the individual to contribute to the full extent of his professional skills. An aspect of this requirement is the need for equality of status in using the facilities that are available; similar needs exist in the area of records (or other information) and the extent to which these are open to each member of the team. The availability, access and control of the supporting services of the team and the relationship of clerical and administrative personnel to the different professionals are also of great importance. More complex features of the social organization of the team are noted in the following paragraph but these basic features of team organization, which have major implications for communication and control, are central to the composition of the team as a social group and thus to the way it conducts its affairs.

4.4 Although the third issue is treated separately here, the administration and management of the team is clearly related to the matters raised in the previous paragraph.

The important aspects are those relating to the style of team management and to the mechanisms used in creating and maintaining the team. More precisely, they include such aspects as leadership in the team, the possibility of dominance of one group by another, the handicaps and difficulties that individuals may experience in the team setting, and the nature and conduct of team meetings and other shared activities such as case discussions. The brevity of the visits to the eight centres of the study did not permit gaining more than an impression of the ways that these various factors interact in a given setting to produce a team with particular characteristics; without a detailed and perhaps prolonged study of individual teams, it is difficult to draw general conclusions. Also it is fairly clear that traditional management theories or models of management are not particularly relevant either to the tasks of primary health care or to the close interprofessional relationships necessary for teamwork. This is therefore an area in which further research, and sharing of the results, is necessary.

4.5 While it is difficult to generalize about how internal organization can promote team development, it is possible to draw attention to some features of the teams that were visited which did appear to have relevance to this question. One such feature is the sharing of concepts or activities to form a common ground providing cohesion for the team; to some extent a shared approach of this kind is achieved by having patients or clients in common and thus a shared focus for individual skills or activities. Such joint activity may still fall short of a combination of skills and experience as envisaged in para. 1.2, however, and can perpetuate a situation where traditional roles are largely maintained. The concept of "problem behaviour" (as distinct from illness or illness behaviour) that is a feature of the team at the Ommoord centre (11) is an example of a team concept of care in which different individuals contribute both as the providers of professional skills and as members of a team which shares ways of characterizing (or diagnosing) the problems of the client and the skills that are relevant to their solution. Clearly, there are a number of other activities or attitudes which can form a basis for team development and this is simply one example; the point is that they offer two ways for the individual to contribute to the team - firstly, in the sense of a shared common attitude and, secondly, in terms of providing a framework in which individual skills can be developed.

4.6 There are a number of corollaries to the development of shared skills of this kind. One is simply the need for continuity of team membership and willingness to invest time and effort in achieving a common basis for collaboration. It follows from this requirement that if, for any reason, there is a changing team membership in one profession, the development of the team will be handicapped and, perhaps more significantly, the contribution of that profession limited by the lack of experience and adaptation of the profession's current representatives in the ongoing evolution of the team. This problem is linked with the issue of dual loyalty noted in para. 3.34, and, for various reasons, may be particularly relevant to nursing. Also, the mode of employment and economic investment of the physician may mean not only that he is a more permanent member of the team in the longer term but also that he will tend to be more dominant figure in the team.

4.7 Dual loyalty, or the serving of a hierarchical superior in addition to identifying with the goals of the team, is of course a more specific barrier to team development insofar as it handicaps an individual's ability to participate freely in formulating goals or exercising an independent professional role. In considering this issue it is difficult to escape the conclusion that a central difficulty in the promotion of teamwork is that of achieving equivalence of status within the team. This does not mean that the physician, the nurse and the social worker should be equal in the larger societal sense; such an argument would be naive in ignoring different professional roles or purposes, differences in professional origins and education and differences in self-perception of the members of the team. What matters is the exercise of individual professionalism on the part of those making up the team and an acknowledgement of it by others. Factors which handicap its expression or which impose a less-than-professional stance on some team members in comparison with others will therefore diminish the effectiveness of the team as a whole. "Status" in the sense of an inferior-superior relationship between the nurse and the physician is one example of this problem and "difference" in the instance of the social worker being "not like" the nurse or the physician is another. Dual loyalty can be interpreted as implying conditional membership of the team and thus has a similar consequence.

4.8 A related aspect of team membership is that of professional self-confidence. By its nature, membership of a team implies the exposure of one's practice and application of skills to the view of others, with criticism by them from the standpoint of other professions. In areas of clear professional overlap, team membership may involve explicit conflict over patient or client management and treatment but, in more general terms, there are likely to be difficulties in recognizing or appreciating the values and priorities of others.

The point here is that without a clear awareness of one's own professional identity, team membership may be a threatening experience leading either to failure to participate fully or to protection and maintenance of traditional roles.

4.9 Difference in the nature and organization of the teams in the study make it difficult to make comments on their management or internal organization that might contribute to team development; clearly, the pattern of administration within a team is related to its purposes and to the different organizational models described earlier. In the teams based on medical practice (those in Rotterdam, London and Glasgow), in which relatively small groups have the opportunity for determining their style of internal organization and, to some degree at least, the content of their practice, one can argue that the definition of team objectives and the overcoming of conflict between the different members of the team are central to its successful operation. The organizational arrangements observed in Roskilde and in Dalby are related to the looser relationships that exist between the different team members; the problem of sharing objectives in caring for the shared clients of the different professions is also present, although at a rather different level. The main difficulty here appears to be that the mechanisms for achieving a common view of client problems are less effective, making communication between the different professional groups a more important issue in the development of the team. The organizational model of the two centres in Budapest illustrates a different set of administrative assumptions; in this example, the work of the local grassroot team is part of a larger complex of services based on the district polyclinic and the team may thus be expected to derive its pattern of internal organization from the needs of this larger grouping. Organizational relationships between the different team members at the local level are therefore determined by their roles within this structure and interprofessional collaboration in the sense of the development of a local team is primarily influenced by the wider administrative goals of the health and social welfare services.

4.10 While acknowledging these essential differences among the teams in the study, it is noted that there are aspects of the internal organization of the teams which appear to have relevance to their success and which would merit further study. One of these aspects is the problem of conflict, or potential conflict, between team members and the ways in which it may be reduced; a second related aspect is the content of the work of the team and the ways in which the idea of pooling of the skills existing within the team may be realized.

4.11 The problem of conflict arises within an organization when choices have to be made and when different viewpoints have to be reconciled in making these choices. In authoritarian, hierarchical organizations the overt problem may be avoided by the decision-making rules of the structure but in egalitarian organizations which by definition include different professional perceptions of the objectives pursued it is clearly necessary to examine the problem and to find ways of resolving the difficulties. Although this report is obviously not an appropriate context for a detailed account of the methods of conflict management, a number of features of this process have an important bearing on the internal organization of interdisciplinary teams and the success of their internal relationships. A complex analysis of these factors and their interaction is offered by March and Simon (12); in addition to other organizational characteristics they identify, for example, reward structure, commonality of goals, information sharing and interdependence on shared resources as features which influence the degree of conflict within organizations and the ways in which it may be resolved. All of these features clearly exist as relevant variables in interprofessional relationships so it seems reasonable to propose that the extent to which they are recognized and the way in which they are included in the management processes of the team are significant factors in the extent to which it achieves its goals. The point here is not that abstractions of this kind are a useful way of analysing or criticizing the organization of a particular team (although that may be the case); it is that for an interdisciplinary group to function in a genuinely collective way, it is necessary to recognize and take account of factors of this kind and to reflect them in the group's internal organization.

4.12 Recognition of these requirements for team organization is of course related to the work content of the team, to the "legitimacy" of particular activities and their acceptance as appropriate concerns. In this regard, it may be possible to argue that there are different stages in which both the nature of professional relationships and the work content of the team develop concurrently. In the early stages of professional interaction, the relationship is essentially one in which traditional roles are accepted and the work content of the team is the sum of the referrals between its members, each of whom is "prescribing" the services of the other.

This phase of development is primarily one of learning each other's skills and, as Lamberts and Riphagen (13) have report from Ommoord, it may take a long time to move to a situation in which common or shared skills are developed. Further, it is at this stage of development that the external factors discussed in section 3 of the report have their greatest influence in either encouraging or inhibiting closer relationships. Establishing these relationships also depends on resolving the issues noted in the previous paragraph and leads on to the situation, also described by Lamberts and his co-workers, in which the content of teamwork begins to change. The process here seems to be that shared perceptions of the nature of problems with which the team is concerned create differences in the recognition of what is legitimate in the provision of primary health care. In one example, in both centres in the Netherlands, there seems to have been as regards the question of how to respond to the presentation of psychosocial problems, a progression in developing a number of team solutions which may be seen in different ways - as concomitants, as alternatives and as additions to the traditional roles and responses of the various team members. The experience of these centres illustrates the way in which a team can become "more than its parts" but also highlights two related aspects of teamwork. The first is that of shared philosophy, whereby individual members have attitudes and ideas in common and can thus make certain assumptions about each other; the second is that of the shared attitudes providing a basis for identifying the team as an organizational entity.

4.13 In adopting Lamberts and Riphagen's model of the evolution of team relationships (at least as it applies to medical-practice model), it is important to echo their caution in accepting the view that the degree of integration achieved at Ommoord can be easily developed as a general health service model. Clearly, a team's place within the health care system is important in influencing the environment of interprofessional collaboration; but beyond a certain stage the degree of integration depends much more on the interpersonal relationships and the self-perceptions of the individuals concerned. Even with goodwill and determination at this level, the problems encountered are difficult ones that require a high degree of commitment to the concept on the part of those concerned.

4.14 One means of reducing these difficulties employed in the two centres in Rotterdam (and elsewhere in the Netherlands) is relevant to solving the problem of overcoming the internal stresses of team development; it is the use of a group counsellor who, as a consultant, works with the team in helping them to determine the nature of the stresses and to work out ways in which they may be resolved. Group counsellors are employed in the Netherlands to encourage group enterprise in a variety of fields and so their involvement in health care teams is simply an extension of their role in other contexts; professionally, their background is in social and organizational psychology, so their function is that of analysing the nature of existing group relationships and of helping the members of a group to gain insight into the origins of their problems and the changes that they must make in order to achieve the organizational goals they have set themselves. The approach and extent of involvement of counsellors obviously depend on particular circumstances but their participation may comprise a discussion lasting two to three hours each week over, say, a six-month period with the possibility of being recalled at a later stage if issues which threaten the integrity of the team arise.

4.15 Although related to the more general organizational climate that exists in the Netherlands, where the activity did not appear to pose any sort of threat to those taking part, such committing merits more detailed description and consideration of its possible application in other situations. If the analysis of internal organizational factors outlined in this section of the report is correct, then it seems logical to argue that assistance in developing team relationships that goes beyond simple administrative measures is a necessary part of encouraging a more general adoption of the team model of health care.

4.16 Before concluding the discussion of the internal relationships of the team, it is pertinent to draw attention to other features which may have relevance to its development. One of these is the availability of time for team activities and the extent to which they conflict with other priority activities or encroach on the free time of individuals. Quite obviously, the development of team relationships requires time for meetings and other discussions and a failure to acknowledge this need will lead to frustration or dissatisfaction; in addition, different professions may have different needs for discussions of this kind so that a further requirement is a willingness to acknowledge and respond to the difficulties expressed by other groups. This problem can also arise when team members are part-time and have other commitments elsewhere as, for example, in the case of a part-time nurse with domestic commitments or a physician who undertakes responsibilities outside his ordinary practice and thus outside the team.

In the former example, frustrations may arise because of the inability of the part-time member to contribute as completely as full-time colleagues; in the latter instance, friction may arise for similar reasons through comparison between the larger concerns of the physician and the needs of, say, the nurse and the social worker whose professional focus may be more closely related to the population served by the team.

4.17 The problem of dual loyalty was discussed earlier in terms of the ways it may blur the identity of the team and lessen the ability of its members to commit themselves to its goals. At the same time difficulties may arise from the administrative definition of professional roles within the team, as the team members must be able to sustain and develop their professional identity and not have it distorted or subverted; it is important to ensure, for example, that the nurse develops as a nurse and is not turned into a doctor's assistant. This does not appear to be a serious hazard in the centres visited except, possibly, in the rather particular case of the specialized nurses at the Dalby centre; but it is nonetheless important to give attention to this possibility in the discussion of team development. There are two aspects to the problem: firstly, the individual needs to be supported in his or her contribution to the team by identifying and seeking to correct specific deficiencies or difficulties either educationally or by such means as group counselling; and, secondly, it is necessary to provide opportunities for exchange of experience and the discussion of common problems in ways that allow them to be formulated in more general terms and their implications understood. It is not a criticism of the individuals concerned to say that one impression of the visits to the eight centres was that the need for support activities of this kind, although felt by all team members, was expressed most clearly by nurses. While one can here only speculate about the possible reasons for this, it may be that nurses in the community are more exposed to problems of role definition, on the one hand, and educationally less well prepared to resolve them, on the other.

4.18 An interesting comment in this context was expressed by a nurse; it is that the leadership exerted by physicians in team situations is only in part attributable to such reasons as their traditional status and dominance and that a further reason for their leadership is more simply that they are educationally better fitted for the internal debate and external negotiation that the team requires in its organization. The real causes of medical dominance, which was clearly evident in all eight centres, must of course be many and complex and it is outside the competence of this study to do more than draw attention to it. The significance of the comment reported above is not that it offers a partial explanation of the present role of the physician but that it draws attention to the perceived disability of the nurse. In more general terms, it is an argument for regarding the educational needs of the nurse in a wider way than has traditionally been the case.

4.19 In discussing the internal organization of the team it has been difficult to avoid a tendency to relate the issues that seem relevant to a theoretical approach to team care. In concluding this section, therefore, it may be as well to draw attention to conflicting features of the discussion. First it is necessary to reiterate that there is no one best way of organizing team care and to endorse Hicks' view (3) that interprofessional relationships are in many senses "personal" to those involved in them. Further, the traditions of different caring professions and their administrative history together with the professional self-perceptions of the team members and the role models with which they identify are important determinants of team practice. This said, however, there does appear to be a logic of team care in the sense that if one begins with the definition of teamwork quoted in para. 1.2 and adopts it as a desired goal, then a series of further concerns must be considered. Within the team there is a need to achieve a balance of team membership which allows a coherent range of skills to develop; to create group identity which perhaps requires the performance of activities that team members can have in common; and to establish equality of involvement in the management of the team's affairs which in turn implies quite sophisticated understanding of the dynamics of the group and the ways it can satisfy the needs of its members. All of these requirements for team care have consequences in themselves: for the deployment of personnel, for the provision of facilities and for professional education. The general problem presented by the concept of the team, therefore, is that its adoption as a goal in the provision of primary health care requires that positive changes be made in policy which will not only create the environment in which teams may evolve but will also encourage this process of evolution in specific directions. These changes would include, for example, changes in the content of primary health care (cf. the example of legitimacy in para. 4.12), in the role and status of the different professions (specifically, nurses and social workers) and in the education that is appropriate for team practice.

4.20 It is important to stress again that the above are conclusions based on the impressions gained in a short study; the most important conclusion is that all of these general statements require exploration in greater depth and a much more specific analysis of their implications. There is therefore a good case for detailed research in a number of areas. Many of the types of research are evident from the foregoing discussion but they include: comparative studies of different forms of team organization and management; studies of changes in professional skills, attitudes and self-perceptions as a consequence of team practice; studies of the resource needs of teams and their capacity to establish collective priorities and to respond to them; studies to determine educational needs in team practice and the way they may be satisfied; and studies of the alternative forms of health care that may evolve in teams and their evaluation. This is only a partial, exemplary list of topics for study; it is evident that each gives rise to a much larger number of specific questions for which answers should be sought through research. As a final comment, it is worth drawing attention to the desirability of research which will allow comparisons to be made between different centres and experience to be shared. Although there are quite obvious differences between the centres in the study and the organizational environments in which they function, there are also similarities - principally the fact that all eight centres are concerned with broadly similar problems in the populations they serve. It would be unfortunate if the obvious differences acted as a deterrent to collaboration in areas of significant similarity.

5. The individual within the team

5.1 In the introductory section of this report the question was raised of whether participation in a team enhances, facilitates or improves the individual professional contribution of its members. The study is not designed to answer this question in a formal comparative sense and the best answer that can be offered as a result of the visits to the centres is that all of those with whom the question was discussed find participation in a team preferable to the alternatives. This comment of course leaves open the further question of whether these individuals are in some way self-selected, so that teamwork may be satisfactory for them but not for the generality of their peers.

5.2 There are no simple answers to the problem of formally evaluating the team in terms of its value as a basis for professional practice; this is partly because the content of the professional task is neither fixed nor easily defined and partly because teamwork is a complex activity which may enhance some features of the professional contribution while leaving others relatively unaffected. One is thus left with the difficulty of making judgements about the value of different aspects of the role of the individual professions. Such judgements are in fact made as part of the ongoing process of professional self-perception so that one pragmatic way out of this difficulty is simply to determine whether a particular organizational arrangement satisfies the prevailing expression of needs and values in a better or worse way than another. Evidence on this point may be available in the case of teamwork in some countries (in the Netherlands (14) and the United Kingdom (15,16) for example) but even then one is left with the problem of whether such evidence can be generally accepted in the absence of experience of alternatives. A more serious objection concerns one's view of the extent to which the self-interest of individual professions should be subject to the differently perceived goals of community health care. In other words, in seeking to assess the team as a form of professional organization, it may be necessary to balance the benefits to the professions, as such, against the benefits that the team may collectively provide in caring for its clients.

5.3 The balance of evidence in the study is that the argument concerning evaluation may be more theoretical than real but in stating this conclusion it is important to emphasize one of the underlying themes of the report: namely that teamwork, while facilitating the contribution of individual professions, also creates pressures for the modification of roles and for the adaptation of skills in directions which are likely to move people away from traditional perceptions of appropriate tasks. The consequence for the individual is the emphasis placed on professional self-confidence as noted in para. 4.8, and the need to have a secure professional identity in a situation where one's role is less easily described in terms of the tasks it encompasses. In part this comment leads one back to the matter of the administrative definition of professional tasks, which at least provides a more secure view of the nature of the job, but it also draws attention to another feature of teamwork which may be significant for the individual. In general terms this feature is the ability of team members to acknowledge and support the role of others or, alternatively, the potential for conflict over individual roles within the team and the possibility of modifying or distorting the contribution of one team member in order to serve that of another.

The latter difficulty can find expression in a variety of situations but one which is perhaps most likely to be encountered is that of the risk of the nurse becoming a "doctor's assistant" and diluting her nursing contribution with simple medical tasks.

5.4 Although administrative arrangements both inside and outside the team setting affect the hazards of teamwork, it is also clear that professional education at all stages is perhaps the one single factor that most influences the successful evolution of team care. Much of this report has been concerned with teamwork as an expression of professional collaboration and much of the discussion has hinged on such topics as the roles of the individual professions and the factors that either encourage or inhibit their development. Since it is through professional education that the individual acquires not only the skills of his discipline but a view of its role in society together with that of related disciplines, it follows that the individual's capacity to meet the demands of team practice (in contrast to the simpler practice of one's own profession outside the team, as discussed in para. 4.8) depends on the orientation of his education and the values it engenders. Elaboration of this issue requires a longer critique on professional education than is appropriate to this report and particular comments would of course need to be relevant to the educational arrangements for different professions in different countries.

5.5 The above comments notwithstanding, one can draw attention to educational topics that may be of significance for later team relationships; these include improved appreciation of the nature of the different professions and their skills (a process at present often left to *ad hoc* encounter); recognition of the wider educational needs of some professions (for example, nursing) if their members are to play an effective wider part in the management of the team; and identification of skills that are of particular relevance to team in contrast to individual practice. Gallagher (17), in a review of the educational problems of teamwork, quotes Bennis (18) as identifying three criteria of "organizational health" and discusses the need for education to fit individuals for team practice. The three criteria are: adaptability or the ability to solve problems and react with flexibility to changing environmental demands; a sense of identity which is similar to the notion of professional self-confidence mentioned earlier; and the capacity to "test reality" which is a rather more complex criterion related, in this context, to the ability to relate professional skills to the characteristics of the client population. Gallagher goes on to comment that conventional training programmes do not satisfactorily meet goals of this kind. The argument is of course one that breaks away from the traditional approach to professional education in emphasizing manner of application of professional skills in addition to the gaining of the skills themselves. The evidence from the present study is impressionistic but, such as it is, the experience of individuals in the teams visited during the study suggests that the argument is one that merits further exploration and discussion.

5.6 The study does not specifically include an enquiry into methods of team education, although informal evidence was obtained of continuing education related to teamwork in most of the centres visited. There is a case for clearer identification of the educational needs of the individuals working in teams and of the methods that may be appropriate for this purpose. There are three areas on which such a further study might focus: the nature of the postbasic education needed as preparation for membership of a team; the nature of continuing education in the context of teamwork, including identification of the educational needs of both the team and its members; and the collective education of the team. This last topic has two aspects: that of enabling members of the team to learn more about the skills of other members and the contribution they might make; and that of enabling the team, as a group, to develop and extend its activities in areas that are not traditionally part of the sum of individual skills contributed by the team members.

5.7 In concluding this discussion of the relationship between the individual and the team it is necessary to go back to comments made at the beginning of the report. The team is one form of organizing the provision of health care in the community and adoption of this mode of organization has important implications for the ways in which individual professions will change and develop. Education for teamwork is important because it involves assumptions about professionalism, as illustrated by the contrast between the centres in Hungary and those in the Netherlands, and thus about the status and functions of professions. In this sense the team is the end point of a much more complex process of change so that, in asking what one wishes the team to be, it is necessary first to ask questions about the nature of different professional groups, their relationships to each other and the changes one wishes to bring about. Education for teamwork is thus a part of this much larger process.

6. Conclusions

6.1 In this report an attempt has been made to identify the general issues that relate to the development of health care teams; indeed, the nature of the study on which it is based makes it difficult to do more than map those topics that appear to be relevant to the concept. In concluding therefore, it is perhaps worth repeating the distinction made earlier between general factors pertinent to the growth of teams and local factors which shape teams in their individual settings. The report has focused on the former set of issues and may, for this reason, appear to be overly theoretical. This approach was adopted for two reasons: (i) to examine the concept of teamwork as an aspect of health care policy and to relate it to the much wider issues, such as the nature and content of primary health care, from which the concept derives and (ii) to give an account of the influences on team growth and development which might be of value in setting the situation of individual teams and the problems they experience in a broader context. It has not been possible to devise a methodology for evaluating the effectiveness of teams, as mentioned in para. 1.3, but it may be that the problems and difficulties described in the report will provide a framework for analysing the progress teams have made in the context of particular administrative and professional assumptions.

6.2 The relationship between the team as a form of local organization and health care policy is clearly an important issue in a number of ways, perhaps the most significant observation from the standpoint of this report is that, with the possible exception of the highly structured system observed in Budapest, many of the teams appeared to have a relationship with the larger system that was to some extent ad hoc and was sometimes at odds with the administrative setting in which they were located. At the same time, however, many of the problems the teams appeared to encounter, and many of the checks on their further development, derived from these external relationships rather than from the collaboration between the members of the team themselves.

6.3 Issues of this kind are relevant in a number of ways. All of the health care systems of Europe are facing a changed pattern of demography and morbidity, with emphasis on such problems as the care of the elderly and the long-term management of chronic illness and consequent difficulties in containing the increasing costs of health care. There is a growing appreciation of the need to seek alternatives to traditional forms of health care provision (19) and it is at this level that teamwork as a concept must first be tested. Does the team provide a more satisfactory alternative to the traditional organization of community health care and, if one can answer this question affirmatively, what consequent changes of policy are necessary to extend and develop this model as a general organizational pattern?

6.4 An attempt to answer this question would require a review of primary health care policy that goes well beyond the scope of this report; it is sufficient to say here that the question is one that needs to be asked. A partial answer is found in section 3 of the report, however, where various external influences on the development of teams are identified. The three issues of greatest significance in this section appear to be (i) the autonomy of the team and its accountability both to the larger system and to the population it serves, (ii) the possibility of regarding the team as the basic unit of primary health care and, as a consequence, the organizational and administrative assumptions that may need to be modified and (iii) the nature of the support needed by the team if it is to function as the primary unit of health care for defined communities. At one level it is possible to treat these issues separately and to seek pragmatic solutions in each case; indeed, at the stage of team development observed in the study it may be preferable to adopt such an approach. At a more fundamental level of policy formation, however, the three issues are really expressions of a theme that underlies much of the discussion of section 3: namely the nature of the relationship between the professions together with their perceived tasks and the larger health care system together with its perceived objectives and responsibilities. Perhaps the one firm conclusion that emerges from this aspect of the study is that the relationship is not well understood and merits more detailed analysis.

6.5 When, in section 4, one turns to the internal organization of the team a similar set of problems emerges in the sense that it is relatively easy to make the comment that the team is a complex organization subject to a variety of internal pressures that are susceptible to social science research and analysis. The difficulty is primarily that while it is possible to characterize such situations by analogy with other examples of small group behaviour, research in these aspects of health care teams is relatively scarce although, where it has been undertaken (20,21), its value as a guide to organizational practice becomes evident.

Section 4 discusses a range of internal organization topics that to some extent form separate analyses; but some are related to the issues raised earlier. As an example, the issue of the team as a unit of community health care can also be seen as one of wider policy but it raises a number of questions about the internal organization and functioning of such a group. If it is to function satisfactorily from an external point of view it will be necessary to ensure that it can meet the conditions for internal collaboration and cooperation. This point is discussed with simple examples, in paras 4.5 to 4.8 which deal with the development of shared skills, the problem of dual loyalty and the need for continuity of team membership. Thus the study has dealt with problems of this nature but it has not been possible to determine their real significance or to evaluate their consequence in an objective way. Their influence on team development and the ways in which they may be overcome is an area for further research.

6.6 The last section of the report, which briefly reviews the relationship of the team to the individual professions, brings the argument in a full circle and again shows the team as the point of interaction both between the health professions and between the professions and the organizational setting in which they function. The argument here has a number of aspects. The social role of the professions is changing and while teamwork may be an expression of this change it is also likely that the team will itself contribute to change, influence its direction and to some extent alter the ways in which professional tasks and responsibilities are defined. These changes have implications for the legal or administrative status of individuals; but, more importantly, the growth of teamwork as a form of organization has relevance for professional education in fitting the individual for a more flexible, adaptive approach to professional practice which does not at the same time distort or comprise professional identity. In parenthesis, but also as an illustration of this point, it would be of interest to compare in some depth the professional characteristics of nurses working in health care teams in Europe with those of nurse practitioners in the United States. Although in many ways different, both modes of employment of the nurse are extensions of the traditional pattern and may thus illustrate alternative approaches to professional development. The argument comes in a full circle because it again shows the team as a model for the organization of services in the community; and at the organizational level it is necessary to ask what, in terms of wider policy, the team is expected to be or to become. The same applies to the professions, for the question of their relationship to the team and its influences on them follow prior questions about their role and the tasks they are expected to undertake.

6.7 By its nature, this report and the study on which it is based have attempted to examine the present state of teamwork, setting out difficulties, problems and shortcomings. Inevitably, therefore, it has tended to present the negative side of the balance sheet and has underemphasized the concern for good practice, the enthusiasm and the commitment to the concept evident in all of the participating centres. And yet this is, perhaps, the most important conclusion of the study. It would be naive to imagine that the problems identified in the report are ones for which there are easy solutions or for which short-term adaptations of the existing environment can be made. The study has provided evidence of problems in the climate of team care but it also demonstrated a high degree of commitment to the care of the client linked to impressive standards for the provision of that care. If it is agreed that "observations must be for or against some view" then the evidence of the visits to the centres was that teamwork is a rewarding form of organization which does have benefits both for those who practise it and for those who experience it as clients or patients.

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This study owes much to a large number of people who contributed freely to both its planning and its conduct. It is a particular pleasure for the writers to acknowledge the help they were given in all of the centres visited and the open and frank way in which problems and difficulties, as well as achievements, were explained. Members of all the professions making up the teams took time from busy schedules to answer probing questions and to discuss both their own contribution to the team and their experiences as members of it. Full cooperation was encountered throughout the visits and sincere thanks are due to all of the people who gave their help.

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REFERENCES

1. Consultative Council on Medical and Allied Services Interim report: future provision of medical and allied services London. H.M. Stationery Office, 1920
2. Hogarth, J. Glossary of health care terminology Copenhagen, WHO Regional Office for Europe, 1975 (Public Health in Europe, No.4)
3. Hicks, D. Primary health care: a review London, H.M. Stationery Office, 1976, p.528 para. 1026
(See also the succeeding discussion in paras 1027-1143, pp 528-586, describing experience with teamwork and the role of the individual professions in the United Kingdom.)
4. Lamberts, H. & Riphagen, F.E. Working together in a team for primary health care - a guide to dangerous country. J.roy.Coll.Gen.Practit., 25: 745-752 (1975)
5. Memoranda, stencils and publications from the Dalby Community Care Sciences Project. Dalby, 1976 (Mimeographed document listing 375 papers and publications on both clinical research and organizational topics.)
6. Magnusson, G. Brief report from a psychiatric research project: new role for the psychiatric nurse at the Outpatient Dalby Health Care Centre, Sweden. 1975 (mimeographed document)
7. An account of the different research projects in progress at Dalby. Dalby Days, November 1976 (mimeographed abstract)
8. Summary of the statistical report of the Ministry of Health, 1976. The people's health: Journal of the Ministry of Health, 58, (4): 236-248 (August 1977)
9. Kaser, M.C. Health care in the Soviet Union and eastern Europe. London, Croom Helm, 1976, pp 166-198
10. Vrey, A. Personal communication. Ministry of Health and Environmental Protection of the Netherlands
11. Lamberts, H. Problem behaviour in primary health care. Rotterdam, Ommoord Health Centre (undated mimeographed document)
12. March, J.C. & Simon, H.A. Organisations. New York, Wiley, 1958
13. Lamberts, H. & Riphagen, F.E. op.cit.
14. de Graaf, H. Op een lijn in der eerste lijn!? Samen werken aan samenwerking /A comparative analysis of teamwork experiences in 15 primary care teams in the Netherlands/ The Hague, Nederlands Instituut voor Maatschappelijk Werk Onderzoek, 1975
15. Marsh, G.A. & Kaim-Caudle, P. Team care in general practice. London, Croom Helm, 1976
16. Law, R. Communication and co-operation within the primary health team J. roy. Coll. Gen. Practit., 20: 6-12 (1970)
17. Gallagher, J. The organisational settings for co-operation between health and social welfare personnel: advantages and disadvantages of various solutions and the role of administration. In: Interaction of social welfare and health personnel in the delivery of services: implications for training. Report of a European Seminar, November 1975. Vienna, European Centre for Social Welfare Training and Research, 1976
18. Bennis, W.C. Toward a truly scientific management: the concept of organisational health. General Systems Yearbook, 7: 269-82 (1962)

19. Mechanic, D. Approaches to controlling the costs of medical care: short range and long range alternatives. New Engl. J. Med., 298: 249-254 (1978)
20. Sundby et al. Some functional conditions and limitations for the co-operation of primary health services with the remaining services of the community. Oslo, Universitetsforlaget trykkincentral, 1973 p.74
21. Sachs, H. & Jefferys, M. Social Research Unit, Bedford College, University of London (unpublished papers relating to ongoing studies of the development of the Kentish Town Health Centre)

Studies on Communication and Collaboration between Health Professionals(Physicians and Nurses: Teamwork)Topic headings for discussions during visits to teams

The headings set out below are intended to provide a framework for discussions of the more general issues described in the Notes on the Study to which this document forms an appendix. Their purpose is simply to provide a framework for the discussions and to outline more specifically the topics that appear relevant to the development of teams. In this context, "the team" is taken to be composed primarily (although not exclusively) of physicians, nurses and social workers; in a given setting, it should be interpreted as referring to the group concerned with the delivery of patient services and to the mode of organization of the group. (To avoid confusion, please note that this is not a questionnaire.)

A. Background information

- (i) The organization and "frame of reference" of the team; its size and composition; its relationship with other organizations and institutions; its place within the larger health care systems.
- (ii) Its relationship to the community, the population it serves and its characteristics, the scope and nature of its services.
- (iii) The membership of the team; their skills and background; their manner of working and the role of each member within the team. How is the contribution of each member defined?
- (iv) The origins of the team and the manner of its creation; factors influencing the numbers of different team members and their relationship to workload.
- (v) Facilities for different team members and their use.
- (vi) The management of the team; its organization and "constitution".

B. Resource provision and accountability

- (i) The perceived objectives of the team; the identification of goals and the formulation of priorities. How are these determined? What are current priorities?
- (ii) How are the resources of the team obtained; what is its relationship to other organizations or institutions in this regard; how do resources relate to priorities?
- (iii) What are the "accountability" relationships of the team? How does it see its relationship to the larger system and how autonomous is it?
- (iv) Is the team constrained by a lack - or an imbalance - of resources and is its practice (as defined in (i) above) impaired by this lack? In what ways?
- (v) How is the contribution (and, separately, the role) of individual team members influenced by the answers to (i)-(iv) above?

C. The environment of the team

- (i) How does the relationship of team members to external agencies influence their membership of the team and the collective working of the team? Such relationships are taken to include:
 - (a) financial or mode of employment;
 - (b) definitions of tasks or scope of duties which may be either traditional or of specific definition;
 - (c) "control" by superiors.

- (ii) What stresses or inhibitions do factors of this kind bring the evolution of the team as an organization?
- (iii) How significant are legal or related constraints to individual professional development within the team and to the team itself? Conversely, to what extent do they protect the professional identity of the individual?
- (iv) What is the relationship of individual team members to others of the same profession? To what extent are relationships of this nature important to the maintenance of professional identity and how does membership of a team influence both the need for and the nature of their relationships?
- (v) What support services are available to the team in terms of:
 - (a) obtaining information about itself and its activities,
 - (b) administrative and organizational support,
 - (c) secondary - or specialized - services and their relationship to the team,
 - (d) other forms of administrative or professional assistance?
- (vi) How are the support services of the team managed and to what extent are they available to all members of the team? What constraints or inadequacies are identified?

D. The internal organization of the team

In this section there is an apparent repetition of items listed above; the difference is that earlier reference is largely devoted to the external environment of the team whilst in this section the topic relates more specifically to the internal working of the team and to relationships between its members.

- (i) Day-to-day working of the team, its organization and "construction", pattern of meetings and discussions, decision-making; identification and resolution of problems and difficulties.
- (ii) The organization of patient services; access to individual team members; referral between team members; development of "new" services and extension or expansion of team skills - by whom, at whose initiative and with what orientation?
- (iii) Record keeping, the form of records, access to them; the sharing of information; mechanisms of communication.
- (iv) The influence of organization (or workload) constraints on the development of team identity (and thus (i)-(iii) above); the relationship of factors of this kind to the status of individuals within the team.
- (v) Professional status and its influence on participation in the team; perceived incapacities and problems of professional identity within the team; recognition of these difficulties and mechanisms for overcoming them.
- (vi) The enhancement or extension of individual skills; the recognition of a "pool of skills" - the identification of needed skills and the way they may be obtained; recognition and "appreciation" of the skills of other members and the maintenance of professional identity within the team; adaptability and flexibility.
- (vii) The relationship of the team and team members to its support services and facilities: receptionists, nursing aides, home helps, etc.
- (viii) The influence of other commitments outside the team setting, which include other professional activities, social or domestic commitments; the effects of part-time working.

E. Education for teamwork

- (i) The adequacy of professional education for work in the team setting; perceived deficiencies; professional orientation and its appropriateness to team needs and goals; conflicts of professional "interest" and their relationship to the success of the team.
- (ii) Specific educational preparation for working as a team; the identification of specific needs and ways they might be satisfied.
- (iii) The definition of team skills, the expansion and extension of individual skills and provision for their development.
- (iv) Collective team education; education in the skills of other team members and the contribution they might make.
- (v) The availability and appropriateness of continuing education; the identification of the educational needs of both the team and its individual members; ways that they are met.

F. General appraisal of team experience

- (i) Does the team facilitate or enhance the fulfilment of individual professional functions (and conversely, to what extent does it inhibit or distort them)?
- (ii) Does the team encourage (discourage) the exercise of independent professional judgment?
- (iii) Does the service provided by the team comprise more than the sum of its parts? In what ways does the team provide services that are different in terms of type, quality or efficacy than those that might be provided by individuals working separately?
- (iv) As a corollary to (iii), is there opportunity for a pooling of available skills in the joint practice of the team?
- (v) Does the team improve access to appropriate skills on the part of the patient/client? Does it alter the understanding of the "relevance" of a particular professional contribution to the client's perception of his problem and its solution?

Main Features of the Reportparagraph
reference

1. The report describes an exploratory study of development of the concept of teamwork in the provision of community health care. For the purposes of the study, the definitions of "team" and "teamwork" are those employed by Hogarth:

"Team: a non-hierarchical association of people with different professional backgrounds but with a common objective, which in any given setting is to provide patients and families with the most comprehensive health care practicable." 1.2

"Teamwork: a method of working towards a common goal which enable several persons to make the best use of their qualities by combining their skills and experience."

In exploring the methodology appropriate for such a study, two broad questions concerning the effectiveness of the team as a form of organization are posed:

- firstly, whether participation in a team enhances, facilitates or improves the contribution of its individual professional members, and 1.4
- secondly, whether the team provides a more balanced and coherent form of health care to the client or to the community than would otherwise be the case.

2. In examining these questions, four topics are identified:

- (i) factors relating to health care planning and the provision of resources for community health care 2.1
- (ii) organizational and administrative influences
- (iii) internal organization of teams, and
- (iv) education for teamwork.

These topics are elaborated in a list of questions providing a basis for discussion in the participating centres. Roughly, section 3 of the report is concerned with topics (i) and (ii), section 4 with topic (iii) and section 5 with topic (iv). Annex I

3. Eight centres participated in the study and were visited for one or two days each, namely: 2.5

The Social and Health Administration of Roskilde Kommune, Denmark

13th District Council Polyclinic, Budapest, Hungary

18th District Council General Practice Centre, Budapest, Hungary

Peijenoord Health Centre, Rotterdam, Netherlands

Ommoord Health Centre, Rotterdam, Netherlands

Dalby Health Centre, Lund, Sweden

Kentish Town Health Centre, London, United Kingdom

Woodside Health Centre, Glasgow, United Kingdom

4. Section 3 describes the principal features of the centres. Four different approaches to interprofessional collaboration are identified, namely: 3.1 - 3.38

- (a) a practice-based model (Rotterdam, Glasgow, London) 3.2
- (b) a social service/nursing model (Roskilde)
- (c) a grouping of services rather than individuals (Dalby), and
- (d) a pattern of organization in which the local team is part of a complex structured system (Budapest).

5. Because of differences of basic structure, it was difficult to draw general conclusions that would apply in all cases but three factors of particular significance became apparent. These are the problem of "dual loyalty", the professional status of the individual team member, and the relationship of the team to the management structure of the larger health care system.
6. Dual loyalty refers to role conflicts due to the way people are employed and the requirements of their occupational position; it may be of particular significance in changing traditional roles and responsibilities. 3.34
- The professional's position in society is subject to influences which include legal status, educational background and, more loosely, a view of the nature and scope of a particular profession. These will have an effect on the capacity of individuals to contribute to team development. 3.35
- The relationship to the management structure of the health care system involves consideration of the constitutional position of the team within the structure and its accountability to the system and to the community. Issues here are the team's ability to determine its priorities and to negotiate for resources, its need for support of various kinds and its capacity to feed information back into the system and thus influence policy. 3.36
3.37
7. Section 4 is concerned with the internal organization of the team and focuses on three topics: definition of the purposes of the team and the extent to which it provides a satisfactory setting for the activities of its members; its organizational environment; and its internal administration and management. 4.2 - 4.3
4.3 - 4.8
4.10-4.18
8. In discussing these topics, the report identifies other features of small group relationships that are pertinent to team practice. These include the need for shared concepts or activities that provide common ground for the team; the importance of continuity of team membership; and problems of professional self-confidence in exposing one's practice to criticism from other professions. Other matters discussed are conflict and its resolution, the "legitimacy" of different activities and their relationship to the evolution of the team. The section concludes with a statement of areas of needed research and a list of topics in which research might be pursued. 4.5
4.6, 4.8
4.11
4.12, 4.13
4.21
9. Section 5 is concerned primarily with the relationship of the team to its constituent professions. It emphasizes the relationship between professional education and work in the team and states three criteria of "organizational health" which may be necessary for team development; these are adaptability, a sense of professional identity, and the capacity to "test reality" in using professional knowledge to meet the needs of people. The argument is put forward that attention should be paid to matters of this kind in professional education. The section concludes with a further comment on relationships within the team as a form of organization and complex processes of change that raise questions as to the nature of different professional groups. 5.5
5.7
10. The conclusion brings together the different topics covered in earlier sections. It notes the problems created by ambiguity about the external relationships of the team but goes on to argue that the teamwork concept must essentially be tested as a means of providing health care in the context of modern patterns of demography and morbidity, e.g. in the care of the elderly and in the management of chronic illness. The last paragraph notes the concern for good practice and commitment to the concept of teamwork encountered during the study and comments that this may be its most important conclusion. 6.2
6.3
6.7

Annex II

OPINIONS, FEELINGS AND PERCEPTIONS OF HEALTH
PERSONNEL CONCERNING THEIR NEEDS FOR CONTINUING EDUCATION:
PROBLEMS OF INTERPROFESSIONAL RELATIONSHIPS¹

The Study grew out of the concern of a group of eighteen health workers about the rapidly decreasing human dimension of care, particularly in hospitals. Members of the group came from a large regional, a psychiatric, and a small district hospital run by a religious order, the University and the municipal health and social services of the commune of Florence. The group included ten professional nurses, three social workers and five physicians, of whom four were psychiatrists and one an internist.

Previous experiences of the group in providing continuing education to activities had produced little change in the behaviour of the health personnel. The group was convinced that continuing education should be programmed around the problems identified by the personnel in their work situation. Further, it was felt that the learning process should begin with the members of the group itself.

A study was designed and carried out jointly by the group members as a learning experience in working together to reach a common goal. (The group went through all the phases of an interprofessional group: enthusiasm, warm-up, uneasiness, insecurity, tug-of-war, appearance of negative behaviour, hostility, trying to come to grips with different value systems, identification with others, and closing.)

Purpose of the study

The general purpose of the study was to secure information on the problems perceived by health personnel in the work situation, which might facilitate their participation in continuing education activities. Factors in the organization of work which might be contributing to the deterioration of care were thought to be associated with:

- the lack of integration of health workers at the inter- and intra-professional levels;
- the inadequate perception of client needs;
- the over- and under-use of health personnel, particularly in relation to the fulfilment of the psychological needs necessary to, and inherent in, collaboration.

The specific objectives of the study were:

- (1) to develop and test a questionnaire to be used as an interview guide for the collection of data on the perceptions, attitudes and opinions of health personnel which motivate them in carrying out their work;
- (2) to gather information on the motivations of health personnel to participate in planned continuing education activities in order to improve the quality of care;
- (3) to gather information on the problems encountered by health personnel in the delivery of care, which could serve as a basis for programming continuing education activities.

Method

Definitions. A list of words and phrases used in the study was drawn up by the group and certain definitions from the WHO Glossary of Health Terminology² were accepted for the study. In all 23 definitions were used. Examples include: motivation, information, role, health care, nursing care, nurse, social workers.

¹ Summary report of a study conducted by an interdisciplinary group in Florence and published by the Department of Health, Region of Tuscany, Italy.
(translation prepared by Miss M.R. Marchi, Dr Vera Maillart and Dr M. Rosselli)

² Hogarth, J. Glossary of health care terminology. Copenhagen, WHO Regional Office for Europe, 1975 (Public Health in Europe No. 4)

Instrument. A questionnaire was designed especially for the study, consisting of 23 open-ended questions and sub-questions which touched upon both intrinsic and extrinsic factors related to work, under the following headings:

- (1) job satisfaction
- (2) content of work (i.e. the work itself)
- (3) interpersonal relationships
- (4) desire for continuing education.

The questionnaire, designed to be used as an interview guide for all categories of health personnel, was tested on a small group. Results showed that only the physicians understood all the questions. Separate questionnaires in more simple and appropriate language were prepared for the auxiliaries and the practical and professional nurses. In addition, five questions were added to increase the information on interpersonal relations, thus bringing the total of questions and sub-questions to 28.

Subjects. The subjects studied were physicians, professional and practical nurses, social workers, midwives, psychologists, psychiatric nurses and auxiliaries working in hospitals and in extra-hospital services in Florence.

Sample. A random stratified sample of the above-mentioned categories of health personnel was drawn from 471 persons employed by the Department of Medicine of the Regional Hospital, the psychiatric and mental health services, and the public health and welfare services of the commune of Florence. The total sample comprised 91 health personnel.

Collection of data

The expressed interest of the President of the Regional Hospital had a salutary effect on the participation of subjects drawn in the sample. Only 15 of those drawn did not participate in the study, either because they did not wish to do so or because they were absent or unable to arrange time for an interview. Thus data were collected from 76 health workers, i.e. 8 physicians, 18 professional nurses, 8 practical nurses, and 15 auxiliaries from the hospital services; and 7 physicians, 4 public health nurses, 3 midwives, 5 social workers, 3 auxiliaries, 4 psychiatric nurses and 1 psychologist from the extra-hospital services.

In all 76 interviews were conducted between May 1974 and April 1975, with time out for vacations, by trained interviewers. Anonymity of the interviewees was guaranteed and, with their permission, the interviews were taped for transcription and content analysis of the responses. Of the 1916 responses, 59 were discarded as tape fidelity did not permit retrieval of the information.

Analysis of data

Data were tabulated according to place of work, category of personnel, position in the hierarchy, years of experience, age (which was not always available or easy to secure, especially for personnel in the extra-hospital services).

Responses were classified into type of response, i.e. generic (more or less general statements such as "change everything", "decrease patients", "increase beds and increase personnel"); pertinent (concrete suggestions of steps to be taken with either a negative or positive orientation); and evasive (a "get-away" comment, an answer that had no relationship to the question, or "I wouldn't know").

A simple three-point scale of the intensity of feeling in the responses was based on the key words used to modify the content of the response, i.e. words such as "slightly, seems, may, some", or "normally, usually", or "absolutely, definitely". The key words permitted an estimate of the conviction of the interviewee in responding to questions. Data were summarized in a percentage distribution for each question and sub-question.

Content analysis was done by panels composed of the group members. Where there were doubts about agreements on the content, a panel of experts was used.

Criteria for classifying the content of the responses were adapted from Ardoino's model of the comprehensibility of organizations. This model distinguishes five levels of functioning in every more or less structured organization:

- at the level of the person (problems of behaviour, motivation, professional attitudes, knowledge);
- at the level of interrelationships (choices, interactions, sympathies, antipathies, indifference, dependencies, rivalries, quality of work, interpersonal relations);

- at the level of group (groups, sub-groups, leadership, roles);
- at the level of organization (technical and operational dimension of groups, how functions are structured for carrying out roles, defining objectives, choices of procedures, work organization, handling of information);
- at the level of the institution (policy and legal problems, rules, standards, values that define rights and duties, status, power, the responsibility of the group as an institution).

Results

Only a few of the general trends which show the orientation of the interviewees can be mentioned, and these may serve to recall the complexity of the task set before the Group. There was almost complete unanimity in the responses to five questions by all categories of health personnel, which may be summarized as follows:

1. The quality of inter- and intra-professional relationships strongly affects the quality of care given by health workers. The three interviewees who did not so believe, it is interesting to note, were working in the extra-hospital services.
2. There is both a need and a desire to participate in continuing education activities, even though many respondents were unable to specify inadequacies in their basic preparation or expressed satisfaction with it. Only four respondents expressed no such need or desire.
3. Continuing education activities were needed also for the auxiliaries. This question was inserted because of the increasing participation of auxiliaries in patient and family care for which they have little or no preparation. Only four of the respondents did not believe preparation was needed for the auxiliaries.
4. Patients and families have health problems which pass unnoticed or are missed by physicians. All categories of health personnel were of this opinion. Unnoticed or missed problems were specified as: human problems, problems of daily living, the personal, family, affective and work problems of clients, problems which have their roots outside the hospital and are brought into the hospital on admission of the patient, and psychological problems.
5. People should collaborate in their own care. Many suggestions were made for ways of encouraging such collaboration, especially for those ethnic and cultural groups who might oppose such practice.

The two motives which appear repeatedly in the responses are:

1. The expressed desire of health personnel to have the opportunity to provide patient and family-centered care.

This motive was affirmed by physicians as the most important aspect of their work. While all physicians working in hospitals asserted the importance of care based on patient needs, they indicated that under the present conditions, time did not permit their dedication to the psychological needs with which the nursing personnel would have to be concerned. On the other hand, nursing personnel perceived the psychological needs as fundamental in care, but expressed insecurity in coping with them.

It should be noted that care was organized largely around techniques and procedures with patients and families as objects; that health workers seemed unaware of the objectives the agencies proposed to reach, both in relation to the client and to the social milieu of which he is a part; that there was little or no continuity of care between hospitals and extra-hospital services.

2. The need for collaboration within and among the professions through democratically-structured teams or working groups.

This motive was found in the responses to questions concerning the meaning of collaboration, the ways of improving the quality of care, and the quality of inter- and intra-professional relationships.

It may be interesting to note that existing difficulties in teamwork were not revealed by such direct questions as, "How would you describe your relationships with your colleagues? Your relationships with your superiors?" which, when answered, were indicated as "Excellent; very good; good". The difficulties inherent in the various components of collaboration in the work situation were shown by responses to more indirect questions, such as "Would you feel free to discuss your work problems with your colleagues or others with whom you work? Would you feel free to discuss your personal problems with your colleagues or others with whom you work? If you had the responsibility for improving the quality of care, where would you begin? How do you think the quality of inter- and intra-professional relationships could be improved?"

The various perceptions of collaboration converged in three dimensions: professional commitment; communication and exchange of information; and group solidarity in problem-solving and decision-making.

Among others, the following needs suggested by the interviewees are relevant to all five aspects of the work situation which were identified:

- (1) to provide an opportunity for health personnel to participate in decisions and to decide about those problems which they face at the level of their own work and for which they have the needed skills;
- (2) to provide for a more democratically-structured approach to the delivery of care by health personnel (away with the hierarchy and with the tendency to form self-defensive groups based on friendship, cultural, social and professional affinities);
- (3) to provide for communication and exchange of information needed to carry out work and improve the quality of care (in the words of one interviewee which summarize what appeared to be the feeling of almost all the health personnel: "Information? There is rather a syndrome of disinformation!");
- (4) to provide for continuous exchange of information about patients and families;
- (5) to provide for clear definitions of the functions and duties of all personnel who participate in care;
- (6) to provide for more and improved preparation of health personnel in the organization of work and in the psychological dimensions of care.

Annex III

LIST OF PARTICIPANTS

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