Two sides of the coin - General Practitioners' experience of working in multidisciplinary teams

Anders Hansson a; Febe Friberg bc; Kerstin Segesten c; Birgitta Gedda d; Bengt Mattsson a

a Department of Public Health and Community Medicine/Primary Health Care, Göteborg, Sweden
b Faculty of Social Sciences, Department of Health Studies, University of Stavanger, Sweden
c School of Health Sciences, University College of Borås, Borås, Sweden
d Department of Nursing, Health and Culture/University West, Trollhättan, Norway

Online Publication Date: 01 January 2008

To cite this Article: Hansson, Anders, Friberg, Febe, Segesten, Kerstin, Gedda, Birgitta and Mattsson, Bengt (2008) 'Two sides of the coin - General Practitioners' experience of working in multidisciplinary teams', Journal of Interprofessional Care, 22:1, 5 - 16
To link to this article: DOI: 10.1080/13561820701722808
URL: http://dx.doi.org/10.1080/13561820701722808
Two sides of the coin – General Practitioners’ experience of working in multidisciplinary teams

ANDERS HANSSON1, FEBE FRIBERG2,3, KERSTIN SEGESTEN3, BIRGITTA GEDDA4, & BENGT MATTSSON1

1Department of Public Health and Community Medicine/Primary Health Care, Göteborg, Sweden, 2Faculty of Social Sciences, Department of Health Studies, University of Stavanger, Sweden, 3School of Health Sciences, University College of Borås, Borås, Sweden and 4Department of Nursing, Health and Culture/University West, Trollhättan, Norway

Abstract
Multidisciplinary teamwork, defined as the collaboration between different professional groups to achieve a common purpose, is commonly regarded as a means to meet the complex tasks that medicine has to deal with today. However, many attempts to introduce the method in primary care have failed and this is supposed to be partly due to the fact that general practitioners (GPs) did not participate in the implementation of the method. The aim of this investigation was to get a deeper understanding of their attitude to teamwork by interviewing nine GPs at four Swedish health care centres, where successful teamwork had been ongoing since 1997. Themes and categories in the interviews were identified according to content analysis. Although the attitude in general was in favour of teamwork, four major themes: time-consuming versus time-saving; shared responsibility versus main responsibility; medical expert versus generalist; shared knowledge versus all knowing, could be identified, which all revealed ambivalence towards teamwork among the interviewees. It was concluded that, if teamwork is to be successfully introduced into primary care, the GPs’ self-perception has to be taken into consideration as has the prestige and status associated with their traditional role and the benefits of teamwork to the profession of medicine. Apart from time, teamwork requires, professional supervision and doctors need to be trained in this method as early as in medical school.

Keywords: Team-working, interdisciplinary, general practitioner, professional role, training, supervision

Introduction
For a long time shared responsibility with other health workers in multidisciplinary teams has been suggested as a way to meet the new challenges and demands facing General Practitioners (GPs) in modern society (Irvine, 1997; Ridd & Shaw, 2006). Many advantages with teamwork have also been reported in terms of the quality and efficiency of medical care (Hasler, 1994; Saltman & Figueras, 1997; SBU, 2002; Grumbach & Bodenheimer, 2004). For 20 years the Royal College of General Practitioners (RCGP) in the UK has recommended that different professionals in primary care should pool their skills and work
together, not only for the benefit of patients, but also to increase their own job satisfaction (RCGP, 1985).

Many evaluations of teamwork in primary care have been undertaken especially in the UK (Long, 1996; Shaw & de Lusignan, 2005) but also in the Netherlands (van Weel, 1994) and the subject is under discussion in medical journals (Waine, 1992; Davies, 2007; Doyal & Cameron, 2000). However different conclusions are drawn regarding how well it works in practice. Generally it was found to be difficult to engage doctors in teamwork. Many GPs were unwilling to participate and thus teams could not be set up (Cook, 1996). Some doctors did not live up to the expectations of the other team members insofar as they did not take on the role of the one and only given leader (Wiles & Robinson, 1994). Conflicts between doctors and other members of the team were often reported, and many doctors thought that teamwork was an unnecessary waste of time (Cook, 1996). It was also suggested that doctors were afraid of losing the position granted them by their traditional role (Cook & Gerrish, 2001; Doyal & Cameron, 2000).

Difficulties in engaging doctors in multidisciplinary teamwork were confirmed by a Swedish study (Hultberg et al., 2003), where focus-group discussions were conducted with health workers who had participated in teamwork at three health care centres in a larger city in the south of Sweden. According to the respondents, there was insufficient collaboration between doctors and other health care professionals. The reasons reported were a shortage of doctors and their lack of interest in working closely with other professionals.

Most Swedish primary health care centres are publicly owned (Saltman & Bergman, 2005). Compared to most other European countries, each Swedish GP cares for a relatively high number of patients and a formal list system is unusual. Group practices (about three-nine GPs working together) are common and single-doctor practices are very rare. Usually, the Swedish GP’s consultation time with the patient is longer (an average of 15 – 20 minutes) than is the case in many other European countries. In most health centres, GPs, nurses – sometimes specialized in diabetes, hypertension and asthma – nursing assistants, receptionists, secretaries, welfare officers and, at times, also psychologists work together most commonly in formal groups (Grumbach & Bodenheimer, 2004).

In this context we define a team either as: “...a group with a specific task or tasks, the accomplishment of which requires the interdependent and collaborative efforts of its members” (Grumbach & Bodenheimer, 2004), or as “...a small group of people with complementary skills who work together to achieve a common purpose for which they hold themselves collectively accountable” (Ingram & Desombre, 1999). Even though the prerequisites for teamwork in Swedish health centres are good, teamwork is rarely found since collaboration to achieve a common purpose is often missing (Hultberg et al., 2003). Yet, there are some exceptions, as mentioned earlier, where teamwork principles are practiced in relation to specific groups of patients, especially patients with musculoskeletal, psychosomatic and/or psychiatric disorders and individuals who risk long-term sick leave.

There have been no studies focusing on teamwork from the perspectives of such Swedish GPs who have experience of long-lasting multidisciplinary teamwork. Therefore, the aim of this study was to explore attitudes to being a part of a team amongst doctors with this kind of experience. It might be that their experiences could help us to highlight the difficulties in recruiting GPs for the teamwork concept?

Material and methods

A case study (Merriam, 1988) of four multidisciplinary teams was undertaken to investigate the participants’ experiences of long-lasting teamwork in the case of patients
with multiple complaints, chronic pain and multifactor causes for their symptoms (Malterud, 1993).

The study was approved by the Ethics Committee of Gothenburg University.

Setting

GPs at five Swedish healthcare centres, where multidisciplinary teamwork was practiced, were asked to participate. The first public health care centre is situated in a low-income district in a smaller rural city. Three doctors serve a population of 6000. The team consists of all the doctors, one nurse, one psychologist, a physiotherapist, and, on certain occasions, a psychiatric consultant who meet regularly one afternoon each week. Teamwork has been going on there since 1997.

The four other public health care centres are situated in the suburbs of a large Swedish city. They belong to a team project which also started in 1997 as a co-financed project between different health- and social-welfare authorities, and which was an attempt to encourage collaboration between primary care, national insurance and social services.

In Sweden three separate organizations are responsible for the health and social welfare system. Sick-leave benefits, disability payment, maternity benefits and pensions are handled by the government-run national insurance system. Local municipal authorities handle social services payment and the county councils run health services, including hospital- and primary care. The GP is employed by the county council to serve in the primary care. The GP can also decide whether a patient does or does not qualify for benefits from the national insurance board.

At the time of the study these teams, who had been trained in teamwork, consisted of all the doctors at the health care centre, a physiotherapist, an occupational therapist, a social worker and a representative from the local national insurance office.

One of these four health care centres is situated in a mainly low-income and multi-cultural area. Eight doctors serve a population of 22,000. In another health care centre four doctors serve a mainly middle-class population of 10,600 inhabitants and finally in the third health care centre four doctors serve a middle class population of 10,900.

Informants

All the doctors at the five health care centres were invited to participate in the study. There was no selection of informants. The chief doctors at the health care centres in question passed on our invitation to participate in the study to their colleagues, after which we got in touch with each volunteer individually.

At one health centre all the doctors declined to participate, giving shortage of time as the reason. Nine agreed to take part.

The informants were between 50–60 years old, five men and four women. They all had more than 5 years of experience as general practitioners and had all been enrolled in the team projects since the start in 1997. Most of the informants had no experience of teamwork beforehand, except for a few sporadic instances, and they were enrolled in the projects on condition that this would be the pre-given working method for everybody employed at the health centre. Although the majority had no strong feelings in favour of the introduction of the method, no one had had any objections to teamwork from the beginning.

The participants were informed about the study, both orally and in writing, and were assured that confidentiality would be respected. They were informed about their right to withdraw from the study, in accordance with the guidelines set up by the Ethics Committee.
Data collection

In the course of 2003 semi-structured interviews (Kvale, 1996) were undertaken with the nine participants. These GPs were primarily asked to reflect on their experiences of working in a multidisciplinary team by means of an open question: “Please, tell us about your experiences of working in a primary care team”. Follow-up questions asking for clarification and to maintain focus on the subject in hand were posed, such as: “What are your positive and negative experiences of teamwork?”, “How did it change your everyday practice?” and “How did it change your role as a doctor?”.

The follow-up questions were elaborated beforehand between the researchers, tested in a pilot interview and then revised to suit the purpose of the study.

All the interviews, conducted by AH, lasted between 1 and 2 hours and were audio-taped. The interviews took place in the GPs’ offices.

Data analysis

A qualitative content analysis, according to Graneheim and Lundman (2004), more explicitly described by Krippendorf (2004), was considered an appropriate method for exploring the informants’ experiences of long-lasting multidisciplinary teamwork.

The interviews were transcribed verbatim and read through several times to obtain a sense of the whole. Then the written records of the participants’ experiences of team work were extracted and brought together into one text, which constituted the unit of analysis. The text was divided into units of meaning. These meaning units were then abstracted and labelled with a code. An example of the procedure is shown in Figure 1.

Starting from differences and similarities, the various codes were compared and sorted into 15 categories. These tentative categories were discussed by the four researchers involved, namely two GPs and two nurses, and then revised. The underlying meaning, that is the latent content, of the categories, was formulated as one major theme and eight sub-themes. Finally, these categories and sub-themes were compared with the original text to ensure they were rooted in the material.

For validation we alternated between different levels of analysis to ensure that codes, categories, theme and sub-themes were grounded in the original data.

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Code</th>
<th>Category</th>
<th>Sub-theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>“You are some type of mediator, the person with the most comprehensive view in the team, in comparison to the health insurance representative, the psychologist, for example, and all those whose financial incitements are different…”</td>
<td>Mediator role</td>
<td>Spider in the web</td>
<td>Generalist</td>
<td>Ambiguity towards the doctors role in the team</td>
</tr>
<tr>
<td>“You are the one who stand for the holistic perspective…”</td>
<td>Overall picture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“You can meet patients’ expectations as to what a doctor should do.”</td>
<td>Expectations on the doctor role</td>
<td>Pure doctor</td>
<td>Medical expert</td>
<td></td>
</tr>
<tr>
<td>“The role of the doctor becomes more refined, as the one who stands for the medical competence…”</td>
<td>Refinement of the doctor role</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1. Example of analysis procedure.
Results

Ambiguous feelings about the doctors’ new role as an equal member of a team were identified as a major theme that we chose to focus on in this report. This is true regardless of the fact that the informants put forward many advantages of teamwork; such as the division of labour, the possibility of being relieved from responsibility, being allowed to devote oneself to the medical task, being able to stand back and occupy a learning position. However, alongside statements about the apparent advantages of teamwork, considerable ambivalence regarding the shift from the traditional doctor’s role to the new role as a democratic member of a team was evident. In the following, illuminating excerpts from the material serve to describe this ambivalence in terms of eight sub-themes and 14 categories – here written in italics.

Time-consuming versus time-saving

Teamwork could be experienced as more time-consuming, compared to seeing the patient for individual consultations, especially when the team had not yet developed efficient routines. Team members were said to be so full of their own agenda that they were not capable of listening to each other’s viewpoints. Statements about this disadvantage have been categorized as discordant talk:

...sometimes it can be a bit tedious, I think, a bit time-consuming, there are a lot of people who have lot to say, who keep talking for a very long time...everybody is full of their own view of the matter...

On the other hand, in the long run, the division of labour meant that teamwork was considered timesaving. In other words, no one had to take on a lot of tasks that did not belong to his/her field. In the course of time, the members of the team learnt to listen and supplement each others’ views, from their own professional standpoints and keep to the matter at hand thus saving time for everyone. Such statements have been categorized as accordance:

...I don’t need to do the job of the psychologist or the physiotherapist...and I’m good in my field...and then we share information and knowledge with each other and help each other...

Sharing responsibility versus having the main responsibility

The informants felt it was a relief to share the responsibility for a patient within a team, especially when a paternalistic relationship had evolved or when the doctor experienced feelings of powerlessness with regard to the patient. As an equal member of a team the doctor was provided with new tools for handling cumbersome situations in the course of everyday work. Together with other members of the team the doctor was allowed to share ideas about the causes of and treatment for the patient’s problems. This was made possible by referring patients between the members of the team. It was also reported that when more than one professional gave the patient the same message, it struck home better and the patient complied with the advice given. Such statements have been categorized here as cooperation:

We can consider together what treatment is the best and the most effective for the patient – conversation instead of physiotherapy for example and this cuts costs.

One can motivate a standpoint from different starting points.
Teamwork could be said to extend the range of the doctor’s work when, for instance, other team members were able to handle tasks such as home or workplace visits by the occupational therapist that are normally beyond the scope of the doctor. Other doctor’s tasks could be similarly delegated to the team members. Such statements have been gathered under the category extension:

(Teamwork) . . . provides you with possibilities for home- and work-visits to another extent.

The participants felt that they could get strength and support from the team. As a team member a doctor could both be saved from the burden of paternalistic feelings and harmful involvement with the patient, and also share feelings of insufficiency and powerlessness with members in the team. The category support was found to cover such statements:

You can be spared the paternalistic role and total responsibility for the patient.

As a result of this joint taking charge, all the members of the team could participate in the responsibility for providing continuity for the patients, even when the doctor was not at hand. Thus, the doctor could be relieved of the total and lone responsibility for the patient. We have gathered such statements under the category continuity:

High continuity (is provided) that doesn’t depend upon one person . . .

On the other hand, becoming an equal member of a team might also mean giving up the leading position the doctor is expected to have, by him/her self, by the patients and by other professionals. But insofar as they had the medical responsibility, the participants saw themselves as the natural leaders of the team. Such statements have been gathered under the category all in one hand:

The doctor has the leading role anyhow as you are the person who has the ultimate responsibility for the patient.

Medical expert versus generalist

It was felt that teamwork gave the doctor the opportunity to become the medical expert s/he was once taught to be. By working with other team members from the psychosocial professions, the doctor could concentrate on medical matters. Moreover, the doctor does not have a monopoly on the truth, or always know what is best for the patient. The distinction between the doctor’s responsibility and areas that belong to the other members of the team could be defined more clearly.

Teamwork was experienced as giving the doctor an opportunity to mark off his/her area of expertise and responsibilities from what belonged to others. Without suffering any anxiety, the doctor could make clear what was within and what was outside his/her area. Such statements have been categorized as explicit bounds:

You go from the position of an all-knowing person to a more limited ‘expert-role’, with delimited responsibility.
It was perceived that by belonging to a team the doctor was able to realize patients’ expectations of medical competence in doctors, this being their foremost role. Such statements have been categorized as becoming a pure doctor:

You can meet patients’ expectations as to what a doctor should do.

According to the participants, one of the doctor’s functions in the team is to serve as an instructor with regard to medical matters, i.e., the person who will explain the functions of the body for the patient. Other typical doctor’s tasks, among others, are to assess the patients’ capacity from a medical point of view, be responsible for medication, distinguish between what is healthy in the patient and the disease and to separate serious organic disease from banal ailments. Such statements have been categorized as doctor tasks:

You become the one whose job it is to “...estimate the patient’s capacity from a medical point of view”.

The respondents also felt that this new role as a pure medical expert could come into conflict with their old role as a generalist. As a generalist, the GP was the one person who had an overview of the patient’s situation; knew what measures had been undertaken, which investigations had been carried out, what the patient’s other medical contacts were, and what treatments had been prescribed. The GP might have a chance of knowing about the patient’s entire life story, including family and relatives. It was thought that as a generalist, one had the opportunity to see to the patient’s whole situation and to help without looking askance at own and others’ financial interests. This overview was now under threat to a certain degree as it was shared by the team. The allegory of the spider in the web was found to be a suitable category to define the old generalist position:

You are some type of mediator, the person in the team with the most comprehensive view, in comparison to the health insurance representative, the psychologist, for example, and all those whose financial incitements are different.

Shared knowledge versus all knowing

In their old role the doctors had to live up to expectations that they were all-knowing and almighty individuals who were presumed to have the answer to every question. It emerged that in a team the doctor could retreat to the position of one who learns, and this had its obvious advantages.

Vague feelings and sentiments the doctor might have concerning the patients in the old role as a lone physician, could be verbalized and systemized in the course of the team’s discussions and the picture of the patient’s situation would become even clearer and more reliable, when the doctor could abandon the position of omniscience. Such statements have here been categorized as a learning position:

[In the old role] ...you got a ‘feeling’ of there being different things that influenced the patient’s health, but you never got at deeper knowledge of the problem in such a structured way...
Through the different educational backgrounds, experiences and viewpoints of the members of the team, the doctor could get a more multifaceted picture of the patient. The doctor’s point of view would be enriched by the new perspectives offered and many new insights and alternative ways of proceeding would appear. Such statements have been gathered under the category \textit{getting new perspectives}:

Many different categories of professionals are needed to get a complete picture of the patient.

At the same time, as teamwork was believed to augment the doctor’s knowledge in one way, concerns were voiced about losing the intimate and confidential contact with the patient, which formerly had provided the doctor with important knowledge. Such statements have been categorized as more \textit{superficial knowledge}:

The immediate contact with the patient becomes more superficial – thoroughgoing contact will be taken over by others . . .

Fear of losing control over the patient, especially in medical matters, and concerns for the consequences this could entail, such as impaired medical service, was noticeable amongst the participants. The category chosen here is \textit{loss of control}:

[You are no longer] . . . the one who has chief control and power over the patient’s disease and its treatment.

\textbf{Discussion}

We presumed that the interviews, with GPs with long-term experience of elaborate and well-organized teamwork, could shed light on some unclear questions with regard to doctors’ attitudes towards teamwork. However, before proceeding some methodological questions will have to be taken in consideration.

\textit{Comments on method}

This is a case study and consists of interviews of some quite exceptional GPs with long lasting experience of professional teamwork, and should not be considered to represent the attitudes towards teamwork of the majority of Swedish GPs. The aim of this paper was to investigate GPs’, who had these specific experiences and perceptions of the nature of teamwork.

In one health centre the doctors decided not to participate in the study despite several invitations. This centre is situated in the same suburb of a large Swedish city, as three of the other participating health care centres, and belongs to the same co-financed project. We have no reason to believe that the doctors at this particular health care centre refused to participate for any other reasons than excessive workload, which is quite a common situation for most GPs in Sweden. We also presume that the doctors at this centre would have had the same experiences and attitudes towards teamwork as their colleagues at the other health care centres that participated in the study.

Interviewing one’s peers involves some methodological issues (Boar & Sims, 2006). For example, a common background and mutual interests may promote confidence in the interviewer, and could augment his/her trustworthiness. On the other hand, an interview
might be apprehended as a test of the professional characteristics of the interviewee, and this could constitute an obstacle to open-heartedness and confidentiality. A need to present an image of a positive and skilled identity to a colleague may shape the informant’s responses. However, there were few aspects of our questioning that could appear to be a matter of checking knowledge and the general feeling was that the informants were quite free and sincere in their comments. Nonetheless, the need to maintain a professional role in the interview-situation, both as interviewer and interviewee, constitutes a limitation in our study.

Comments on results

The results show that the doctors experience a feeling of ambiguity in their new role as equal and democratic members of a team. This emerged as a major theme that we chose to focus on in this study. Simultaneously, as the advantages with teamwork were accounted for, the interviewees appeared to be insecure with regard to the doctors’ position as an equal member of the team. For example, at the same time as people expressed great relief at being able to share responsibility with other members of a team, they also pointed out that someone ultimately has to be in charge and make the final decisions. On the whole, our informants considered the doctor to be the natural leader, with the overarching responsibility for the outcome of the teamwork.

Many health workers today, however, question whether the doctor’s position as leader of the team is a pre-given and natural role in the context of democratic and well-functioning teamwork (Wiles & Robinson, 1994; Cook & Gerrish, 2001). Thus doctors may perceive that what they take for granted is being threatened. It is well known that groups and individuals do not interact and cooperate well when they are forced to defend their territories, and when their goals and intentions are threatened (Hibberd, 1998; Ingram & Desombre, 1999). The latent threat of losing the leading role could be one of the reasons for the difficulties reported in engaging GPs for multidisciplinary teamwork (Cook, 1996; Barr, 1997; Hibberd, 1998).

In this study the participants describe teamwork as both time consuming and time sparing. This ambivalence also was reported in the Hultberg et al. (2003) study. On the one hand the respondents reported feeling frustrated by all the time spent on collaboration while on the other hand they expressed a need for collaboration. There was speculation as to whether the individualized working process, characteristic of primary care, that aimed to provide what was believed to be the best for the individual patient, might have overshadowed the collaborative and interdisciplinary goal formulating process involved in the co-financed project. However, our interviewees considered teamwork to be time saving in the long run. One reason for this difference could be that our interviews were conducted on a later occasion and that when more time had elapsed the team members had learned to take more advantage of the working method.

Another ambiguity lies latent in the dichotomy between the new role as an expert among other experts and the traditional generalist role. According to the interviewees, it is truly perceived as a relief for the GP to become “pure” doctor, as is the case when working in a team, but at the same there is a fear of losing previous, thoroughgoing contacts with the patients. To know the patient as whole person, with a family and a social life, is what traditionally gives general practice its charm and raison d’être, and is what distinguishes general practitioners from other specialists (McWhinney, 1997; Heath & Sweeney, 2005). According to Armstrong, the overview of the patient’s life, is supposed to give salient advantages both with regard to insights into the medical history and considerations
concerning treatment. This is what gives the speciality of general practice its status in relation to other specialities (Armstrong, 1979). When this role is threatened, by the participation of other professionals, what other claimable territories remain for the GP – neither a true family doctor, in the old sense, nor a real medical expert?

This ambiguity is also reflected in the other advantages and disadvantages reported. On the one hand, sharing knowledge with other members of a team is a way to gain more insight and new approaches to the patients’ histories, while on the other there is a feeling of loss of control over the patient’s life. Doctors fear that their knowledge of the patient is in the process of becoming more superficial. But we may ask if this not due to more confusion between two different levels; the one concerns knowledge, the hard facts, about the patient, and the other the personal contact with the patient? When the doctor no longer has full personal responsibility for the patient, s/he may experience this as knowledge becoming more superficial (Hansson et al., 2007).

Van Weel defines teamwork as “a journey through a dangerous country” and traditionally most health workers are poorly prepared for the method (Van Weel, 1994). Members of different professional groups are trained to work as autonomous practitioners and have very little understanding for other professionals’ roles and tasks (Vanclay, 1998). Studies of teamwork in medical care settings indicate that in general the more education a person has the less cooperative a team member, with doctors being perceived as the least cooperative or positive (Davies, 2007). Not least in the beginning of team development doctors tend to live up to the stereotypical image of the profession, and take on the prominent role and be task orientated. They appear to be less cooperative than the other members of the team who have less education (Farrell et al., 2001).

The difficulties experienced by this professional group in adapting to new conditions, as demonstrated by our findings, may be further understood in the light of Maslow’s classical theory about human needs (Maslow, 1943). According to his theory, after psychological needs safety needs have their place on the second level in the hierarchy of needs, followed by love and esteem needs. In our society, where most of the human needs for safety are satisfied on a basic level, people still tend to seek safety and stability by clinging to familiar rather than unfamiliar things, or to the known rather than the unknown. The human tendency to have some kind of a world view that organizes the universe and the people in it into some sort of satisfactorily coherent and meaningful whole is also, in part, motivated by safety seeking. Esteem needs, on the other hand, as expressed in the fundamental need for high self-esteem, can either stem from self-respect or from recognition from other people. This could explain why GPs tend to cling to the traditional doctor’s role when teamwork is discussed – in a new organization, in which teamwork is given a prominent role; there is of course a risk of marginalization (Cook & Gerrish, 2001).

**Conclusion**

The implications of our findings, in combination with what is reported in other scientific studies, are that it is important to consider GP’s self-perception when teams are initiated in primary care settings. New roles will be created for everyone included in a team and they have to be discussed thoroughly amongst the members of the team under professional supervision (Barr, 1997); this applies not at least to the doctors. Otherwise the risk is that doctors will stay outside the development of new working methods in primary care and take up positions similar to the conduct of guilds in the past. Conforming to team work has to take time, as so many reports indicate (Barr, 1997; Vanclay, 1998; Farrell et al., 2001). In fact, if the goal is implementation of optimal cooperation between different professional
groups in primary care, training in teamwork should start in medical school (Vanclay, 1998). If teamwork, in contrast to the individual physician taking the sole responsibility, is the obvious means to meet the complex tasks that medicine has to deal with today – as some authors have suggested (Grumbach & Bodenheimer, 2004) – and if GPs’ are to regain the self-esteem and self-respect they once commanded, they will have to re-evaluate their old standards and reinvent the content of their profession.

Acknowledgements

We wish to thank the participating GPs for their willingness to participate. The project was supported by grants from the research and development council in Fyrbodal, Västra Götaland.

References


