TEAMWORK AND LEADERSHIP IN GENERAL PRACTICE

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INTRODUCTION

Teamwork at its simplest level can be defined as any two or more people who interact interdependently with a common purpose. Interdisciplinary teamwork between health care workers is a key component of general practice.

This chapter will introduce you briefly to the many different types of people who provide care to patients in general practice and primary care. Over the course of your various undergraduate GP attachments you will see many of them at work. We also summarise some of the theory of teamwork and explore the nature and importance of leadership for any team to work well.

NEED TO KNOW

WHO ARE THE PEOPLE WORKING IN A GP SURGERY?

Let's start with the doctors:

- **Partners** - own the business (often including the premises) and keep the profits. Make decisions about what happens in the business.

- **Assistants/Salaried GPs** - are employed in the medium to long term by partners to see patients.

- **Retainers** - commonly doctors who have young families; are paid partly by the partners and partly by the local healthcare organisation.

- **Locums** - are employed in the short term by partners to see patients.

- **‘Out of hours’ doctors** - see patients when surgeries close at 6pm in the evening until 8am the following day - this job used to be performed by partners at surgeries.

- **Practice nurses** - nurses who see patients for health-checks and sometimes minor illnesses.

- **Nurse practitioners** - senior nurses who can see patients with many medical conditions and often prescribe some medications.
• **District/Community nurses** - no longer employed by practices but by local acute or community Trust, they see patients in their own homes who can’t get into the surgery.

• **A wide range of specialised community nurses** - e.g. Midwives, Health visitors, Community Mental Health Nurses, nurses specialising in particular long-term conditions e.g. diabetes, heart failure, asthma, COPD etc.

There are also several other allied healthcare professionals working at GP surgeries:

• **Healthcare assistants (HCAs)** - help monitor/perform investigations.

• **Phlebotomists** - who take blood for investigations.

• **Physiotherapists** - diagnose and treat musculoskeletal problems

• **Psychologists and counsellors** - helping people with mental health issues.

• **Chiroprists** - help people with foot problems

• **Osteopaths** - help people by manipulating painful joints / bones

• **Social Workers** - help people with social problems (housing, family issues)

• **Citizens Advice Workers** - help people with forms, paperwork and benefits

Then there are others who glue this all together, the managers and administrative staff including:

• **Practice manager** - helps the partners run the business and carries out the strategy agreed by the partners. Many practices have deputy practice managers.

• **Receptionists** - help direct patients to the most appropriate care, book appointments, organise appointments at the hospital, issue patient prescriptions and a hundred other things.

A medium-sized surgery serves about 10,000 patients - usually with about 3 or 4 full-time-equivalent (FTE) GPs and has about 40 employees. It turns over about £2.5 million a year. The partners are responsible for the business aspects of this enterprise and meet regularly to discuss business matters. Here partners work in close association with accountants, lawyers, bank managers and practice managers.

A GP surgery has different types of practice meetings so that all the business and clinical care can be co-ordinated. These might include partners’ meetings, clinical meetings, team briefings, administrative team meetings, practice nurse meetings and whole team meetings.

GP meetings commonly have different themes such as ‘education’, ‘quality (discussing significant events and complaints)
TEAMWORKING

As a doctor you will almost certainly spend your entire career working in teams made up of many different types of health workers. Small groups in medical school, clinical teams in hospitals and clinical teams in general practices.

Understanding how groups work is therefore essential to team-working. Fortunately, there has been a lot of research in this area and some of this is summarised in this chapter. However, we would recommend further reading and discussion in this area. See Further learning section below.

The management of teams is an essential part of being any kind of doctor and uses insights from the field of group dynamics. You will be learning about how groups function in your PDG groups. Take an opportunity to apply some of this thinking about groups to the practices where you have your placements. Your PDG (and other small groups) are an important vehicle for you to learn about being part of a group and therefore team-working.

GROUP DYNAMICS

The following extract concentrates on the characteristics of groups that are functioning well and groups that function not so well.

Effective groups
A meeting of partners meets to decide whether to expand the practice and take on another partner. A sensible decision must be made, to do this the group must interact effectively. Here are the characteristics of an effective group:

Aims:
- What is exactly the group's task and aims?
- It must be clearly understood by everyone.
- It must also be relevant to the needs of group members.

STOP – think!
What are the aims within your PDG / PBL groups? Aims change and like all group processes will need to be readdressed from time to time. Problems are seldom sorted out once and for all in groups

Communication:
- Effective communication is a prerequisite in groups.
- Communication can be verbal or non-verbal.
Power:
- Participation is groups should be equal.
- Leadership and responsibility should be evenly shared.
- Power should be based on expertise, ability and access to information, not on who makes the most contributions or shouts loudest. Quieter members of any group often have huge amounts to offer.
- Coalitions will form within groups these should be noted and explored.

Decisions:
- Appropriate decision-making methods must be used. A popular formal method is SWOT analysis - listing Strengths, Weaknesses, Opportunities and Threats of the various relevant factors involved in a decision.
- The group should have a system by which group decisions should be made, and an appropriate amount of time agreed in which to come to a decision.

Conflict and controversy:
- “Since the general or prevailing opinion on any subject is rarely or never the whole truth, it is only by the collision of adverse opinion that the remainder of the truth has any chance of being supplied.”
  John Stuart Mill
- “When two men in business always agree, one of them is unnecessary.”
  William Wrigley

The two words have slightly differing meanings:
- Controversy implies a difference in beliefs between people who work to seek an agreement.
- Conflict implies a difference in opinion, but the aim here is to reach a compromise through negotiation rather than agreement.

In both however, there is a strong emphasis on maintaining a positive approach and reaching an acceptable solution. There are other ways to reach decisions when people disagree, for example debating. Here the aim is to ‘win’, the winner being decided by a vote or judge (e.g. Houses of Commons and Lords in the UK or the law courts). Conflict can seem threatening and is often avoided. There are many ways of avoiding conflict:

1. Deny controversy exists
2. Withdraw yourself from the controversy
3. Give in to the opposing view
4. Rationalise e.g. the issue is not important, you do not hold an opposing opinion, you have no expertise, etc.
5. Overpower those that disagree
6. Intellectualise so that all feelings and emotions are hidden
7. Join in with other group members to smooth over the cracks of uncomfortable conflicts.
**Cohesion:**
- Effective groups have high Cohesion - this is based on:
  - Physical and social attraction amongst members
  - High costs associated with leaving
  - High commitment to group's goals
  - Honesty.

This Cohesion concept is highly valued in Japan where professional groups spend much time socialising and indeed arriving at decisions outside the formal confines of their groups.

Lack of honesty is perhaps the most potent destructor of group cohesion. As groups mature, discrepancies between individuals’ spoken intentions and their actual behaviour assume ever greater importance. Sometimes this discrepancy is unknown to the individual, it is part of the individual unknown to himself, but often known or appreciated by others - these are our Johari's Windows.

Groups can be effectively used to balance up these discrepancies in ourselves. (Or read 'The Trial' by Franz Kafka). Conscious discrepancies in spoken intent and actual behaviour are known as hidden agendas and can be extremely destructive (whilst being glaringly obvious within established groups).

In general, effective groups must have the following 3 properties:
- Ability to accomplish aims, i.e. good problem solving.
- Ability to maintain good relationships.
- Ability to adapt to change.

**SUMMARY OF EFFECTIVE GROUP CHARACTERISTICS**

In analysing the effectiveness of any group, think of the following. (Choosing and discussing one of these areas is an interesting exercise for an afternoon)

- Aims
- Communication
- Power Distribution
- Decision making ability
- Management of Conflict
- Group Cohesion
INEFFECTIVE GROUPS

In the analysis of medical errors and sub-standard care, the common factor is always that clinical teams have been very dysfunctional. Learning to spot dysfunctional group characteristics is therefore very important. A lack of the 6 preceding signs of effective groups will often be evident. However, certain types of behaviour are also indicative of ineffective groups, some examples are:

**Free rider effect**
Decreasing amounts of effort are expended by group members. 'Going through the motions' becomes the norm.

**Sucker effect**
High ability members of the group are saddled with more than their fair share of responsibility.

**Rich get richer**
As a consequence of '2' the more able members spend more time explaining - this correlates highly with the amount learned. Other less able members flounder as 'captive' audiences.

**Self-induced helplessness**
**Over dependence on leader**
**Ganging up against tasks**
**Destructive conflict and arguments**
**Joking and horseplay in inappropriate amounts**

Effective Groups have been shown to make better, more efficient decisions than individuals. The members are also psychologically healthier. The increasing incidence of neurotic disorders in the face of a consistent incidence of psychotic disorders has often been attributed to the breakdown of effective supportive groups (e.g. family/friends). This in turn may be due to greater social mobility and more competitive environments. The re-emergence of small groups such as family and community may be one of the central themes of politics and social organisation in the future.

LEADERSHIP IN GENERAL PRACTICE

Leadership is crucial, so that things can get done. Conversely, lack of leadership can have disastrous clinical consequences. Many of the serious healthcare failings in recent years can be traced back to a lack of leadership by doctors (1). We all have a duty to assume leadership roles when the situation arises, and this is recognised by the GMC (2).
Many of you will already have a leadership role. This may include organising a study group, leading a session on a clinical topic, supporting students in earlier years, organising outside activities with friends or for an organisation such as a sports club.

- *Take a moment to consider what 'leadership roles' you have (clinical and non-clinical).*
- *What things work for you in these roles and what things don’t?*

**Leadership characteristics**
Leadership is process of influence in which a person can enlist the aid and support of others in the accomplishment of a common task. It is different from 'management', which concentrates on the delivery of the vision; ensuring that timelines are met, risks identified and mitigated, and resources appropriately allocated.

Styles of leadership vary, and the skill of a good leader is to be able to vary their style according to the task involved and the people they are working with. Autocratic leadership might be most appropriate when leading a cardiac arrest team, but a more democratic leadership style might be better for a group of GPs working on a service development project. Take a few minutes to read about different leadership styles: [https://www.mindtools.com/pages/article/newLDR_84.htm](https://www.mindtools.com/pages/article/newLDR_84.htm)

**Leading change**
Leaders tend to have characteristics that match the stages involved in leading change (3,4).

1. Creating and communicating a vision for change, together with an explanation why that change is needed, and is needed now. (Vision)
2. Motivating and inspiring people to engage with that vision. (Human relations)
3. Translating the vision into a process that has the right people in the right roles (Operational)
4. The resilience to deal with uncertainty, messiness, complaints and setbacks that typify change management.

In summary, leadership brings together 4 key skills needed to complete 4 key tasks:
- Vision
- Human relations
- Operations (the ability to translate vision to achievable actions)
- Resilience.

Very few people have all these skills, and therefore one of the key aspects of leadership is 'self-knowledge'; the ability to identify our own strengths and weaknesses and to find the right people to fill the gaps.
Distributed leadership and followership
It is important to recognise that people with a nominal position of leadership may not actually be ‘the leader’ of a team for a task e.g. it may be the Registrar leading the daily ward round rather than the Consultant. The Leader may also vary from task to task. The value of this distribution of leadership in a complex system such as healthcare is that everyone can use their varying leadership skills to develop different tasks rather than all the responsibility resting on one person whose style may not suit the variety of work (5). This model of Distributed Leadership also emphasises the value of ‘Followership’ - not everyone can be a leader but to be effective they need ‘followers’. There is a well-known video that summarises this (6).

A warning! Motivations to lead...
Despite the theory, some people in senior leadership positions display few of the above characteristics and are frequently driven by motivations to prove themselves or to dominate. Many failings in healthcare have been due to poor senior leadership remaining unchallenged (1).

- Consider what your actions might be if you had to work with such people and had concerns.

ACTIVE LEARNING

Teamwork:

✓ Try and make a list of the healthcare professionals that you come across.

✓ Whenever you meet a different professional ask them about their role and what their typical day is like. Ideally over a cup of tea!

✓ Consider the attributes of effective and ineffective groups - can you see any of these at work in groups that you are part of.

✓ If you can see positive attributes in a group, how could you encourage the group to do more? If you can see negative attributes how would you go about addressing these?

✓ Take a moment to observe how verbal and non-verbal communications match in a group.

✓ Think about how you deal with conflict and controversy.

✓ Can you see any of the avoidance tactics above at work in your placement?
Leadership:

✓ Who are the effective leaders on your placements? Are they in leadership roles?

✓ What makes them an effective leader?

✓ What have you seen them do that makes them effective? How do they achieve ‘vision’, ‘human relations’ and ‘operations’? What can you learn from them?

✓ What sort of ‘leader’ are you? What are your skills? What do you think you need to develop to become a more ‘effective’ leader?

FURTHER LEARNING

Teamwork:

Look at the following link offering some down-to-earth advice about team-working: http://www.pulsetoday.co.uk/how-toensure-good-teamwork-in-the-practice/10943482.article

Also, this report from the King’s Fund on teamwork in general practice: https://www.kingsfund.org.uk/publications/effective-teams-general-practice

Leadership:


6. Dancing Man - there is no movement without a follower! https://video.search.yahoo.com/yhs/search?fr=yhs-gemni-hp&hsimp=yhs-hp&hspart=gemni&p=youtube+dancing+man&id=2&vid=b48ef94a51b65739b2aceaf712c5b40&action=click
The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC’s Heads of GP Teaching Group.