Role Identification

An Impediment to Effective Core Primary Health Care Teamwork?

JEAN ROSS

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by

JEAN ROSS

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Abstract

This study, which is methodologically grounded in qualitative research and philosophically informed by critical social science, explores important aspects of the socio-political context in which practice nurses and general practitioners (core primary health care team) work within a team environment. It is indicated in the literature that there are benefits for improved health care through the development of collaborative teamwork. However, there have been many barriers identified which prevent collaborative teamwork. Amongst the many barriers, is the lack of role clarity and attitudinal differences. Role clarity and attitudinal differences are the topic of this thesis. This thesis explored and highlighted whether the lack of role clarity and attitudinal differences do indeed impede the team's success, and are barriers to teamwork. The views and opinions of practice nurses and general practitioners understanding of their own and each other's current roles within the general practice setting were explored. The participants had the opportunity to discuss together, in focus group meetings, their thoughts on the topic. This raised their awareness of their taken for granted ideas on role and teamwork. Focus groups offered the participants the added opportunity to question each other which allowed for a deeper and more fulfilling understanding of role. New understandings that emerged could lead to alternative models of health care and influence the future delivery and planning of general practice. The thesis concludes by offering a potentially suitable model/ framework which has been developed to further the understanding of teamwork in the future.

Preface

The existence of an other resolves the problem of loneliness but brings with it anxieties for the individual, for inherent in any relationship is, inevitably, some form of power struggle. This is the existential dilemma confronting the individual, in relationships with parents, partners, family, friends and larger collective groups. Human history abounds with cases of the individual being induced by force or ideological persuasion to submit to the power of the collective; the surrender of the self to the collective eventually becomes habit, norm, convention and tradition, and this phenomenon is not unique to any one culture.

"Soul Mountain" is a literary response to the devastation of the self of the individual by the primitive human urge for warmth and security of an other, or others, in other words by socialised life.

(Gao Xingjian translated by Lee 2000 p. vi)

*With love and gratitude to those who have provided
guidance, mentorship and encouraged
me to seek below the surface.*

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CHAPTER 1
Introduction to the Research Topic

*Teams which are more participative and collaborative are
more likely to achieve a patient-centered service, to work
together as a team and be more efficient.*

(Poulton & West 1999 p. 17)

1.1 Introduction to the Research Topic

This thesis has commenced with the above quote, as it provides me with a sense of wisdom,
vision and direction implying that for the delivery of effective primary health care, health
care practitioners need to work as a team. The importance of effective teams within the
primary health care setting have been highlighted in a number of international studies;
Ducanis and Golin (1979); Kohn (1983); Ovretrivt (1990); Isles and Auluck (1990); Waine
(1992); Katzenbach and Smith (1993); Poulton and West (1993); Poulton and West (1999);
Williams and Laungani (1999). Researchers based within New Zealand (Toop, Nuttall &
Hodges 1996; Toop & Hodges 1996; Opie 1997) also put forward the same argument.
Additionally, a number of recent New Zealand government reports, the Health Funding
Authority's "The Next Five Years in General Practice" (1998), the Ministry of Health's
Report of the "Ministerial Taskforce on Nursing- redressing the potential of nursing"
(1998a), in addition to the Ministry of Health's draft discussion documents "The Future
Shape of Primary Health Care" (2000a), the New Zealand Health Strategy (2000b) and
more recently the "Summary of responses to the Future Shape of Primary Health Care"
(2000c), highlight the value of health professionals working together as a team.

These documents emphasis that a team can provide effective and comprehensive health care. Despite this, there is little evidence in the literature supporting the notion that teams in primary health care actually do adopt a collaborative model (Opie 1997).

Throughout the development of primary health care there has been continuing concern that there is a significant gap between the rhetoric and reality of teamwork (Poulton & West 1999). A number of examples of barriers to collaborative teamwork have been identified by the following: Ducanis and Golin (1979); Isles and Auluck (1990); Ovretrivit (1990); Waine (1992); Katzenbach and Smith (1993); Poulton and West (1993); West and Slater (1996); Toop, Nuttall and Hodges (1996); Toop and Hodges (1996); Opie 1997 and Elwyn-Jones, Rapport and Kinnersley (1998). The barriers they have identified include, the time it takes to attend team meetings, which conflicts with the valuable time that could be spent with patients. Relationships between health professionals especially the various health professionals caring for the same patient can result in, duplication and fragmentation of the provision of health care. This can lead to confusion for both the patient and health practitioners. There have been a number of professional barriers also identified. These include a variety of professional attitudes leading to conflict, professional rivalry, lack of professional respect and autonomy. It follows that for a team to work effectively and efficiently in primary health care, it is necessary to identify and address these barriers. I have chosen to study one particular barrier to teamwork, that of the lack of clarity and role recognition through practice nurses' and general practitioners' understandings of their own and each other's role in the General Practice setting.

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I offer insights from my professional and personal opinions about teamwork. I believe that practice nurses and general practitioners working in partnership, in particular, are ideally situated to provide efficient and effective General Practice services. This partnership should offer patients and communities an increased set of skills and support, which is greater than that which can be provided by single professional disciplines (Ross 1995). I believe the necessary tool to achieve this is for health practitioners to work within the boundaries of a team.

My research question arose from a series of linked studies I have previously undertaken and am currently progressing with. I intend to extend my insight into these studies, explain and share how my commitment to this topic has progressed. My interest in teamwork began while working as a staff nurse in a secondary care setting in Wales. I became aware of the variety of teams and teamwork that existed and the personal feelings of satisfaction and disappointment which I experienced, when working with a variety of teams. From this initial experience, my interest in teamwork has developed over the ensuing years. The first time I became aware of effective teamwork was when I was a Charge Nurse of a five hundred and fifty bedded District General Hospital in rural Wales. I was the Senior Charge Nurse on the cardiac arrest team while working permanent night duty. I was twenty-six years old and the impression of effective teamwork has remained with me ever since. My memories are of night duty, an emergency, and the most inexperienced young health professional team attending a most dramatic medical emergency in the night; a cardiac arrest. By "young" I mean junior and inexperienced doctors and nurses. We were very much a TEAM and we knew the team goals, each other's roles, functions and attributes. We knew when and how to respond together, to treat and care for the patient and to support

the patient's family. We depended on each other for success and in the event of the patient not surviving the cardiac arrest we depended on supporting each other and the patient's family.

In my opinion this team did not take into consideration issues relating to hierarchy, financial costs or "turf guarding" any of which are all too evident within the General Practice environment in New Zealand (Toop & Hodges 1996). However, there is a different opinion put forward by Meerabeau and Page (1999). Meerabeau and Page undertook a study on teamwork and cardiopulmonary resuscitation. They state that the practitioners studied only came together as a team to perform one main task, a cardiac arrest. The authors of this study imply that the team members did not generally work together and therefore can not be described as a team. However, I disagree. I emphasise that the feelings of belonging, knowing the team's goals, one's own and each others' role or function, and the satisfaction of working together as a team, with all members working to achieve a combined goal, is an overwhelming experience of individuals being united and forming a whole. I put forward the argument this can be achieved within a cardiac arrest team.

Later, in 1992, when I entered rural General Practice in New Zealand, I became aware of the complexity of teamwork compared to my British hospital experience. There appeared to be a number of barriers to teamwork, mainly concerned with funding of General Practice services and the costs of running a health centre. The relationship between the general practitioner and practice nurse was one where the general practitioner was the employer and leader and the practice nurse was the employee and assistant to the general practitioner. This relationship was not one based on teamwork, which, in my experience, required the

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setting of goals, and planning patient care together. Additionally, I was confused with my roles as a rural practice nurse / community district nurse and rural general practitioner's partner. The position I took up as a rural practice/community nurse raised my awareness to the constructed aspects which appeared to be part of this role. This led me to consider the way nurses have been traditionally structured by society into the role of handmaidens to doctors (Williams 2000). I did however, realise I was in another country which had a different health system from what I had previously known. However, my overwhelming impression was that the context in which I was working was not conducive for effective teamwork.

In addition I have taken an interest in the way people and health professionals are socialised within a role. This has profound implications for the expected behaviour of the person in given situations. People are at times reticent about their role and may go on conforming to the expectations placed on the role without challenging these historical beliefs and expected behaviours. I believe there is no place for stereotypical thinking about the role health professionals play and how they should function in that role. In my view thinking in this manner restricts the essence of the team and avoids acknowledging the personal attributes and elements individuals can contribute to the team's success. My concerns about this have increased my interest on teams and role to the extent I have studied this subject in a variety of ways over the past six years.

In 1995 I was invited by the then Core Services Committee (later to become the National Health Committee) of the Ministry of Health, New Zealand, to write and present a paper at a forum on the Delivery of Health Services to Smaller Communities (London & Ross

1995). The aim of this forum was to ensure a stable, content and energised rural health workforce. The paper was titled "Professional Responsibilities Relating to Teamwork in Rural Practice". I later published the paper in Primary Health Care New Zealand unchanged but retitled, "The Positive Aspects of Health Teams in Rural Areas" (Ross 1995). This invitation stemmed from my position as Co-Director of the Centre for Rural Health.

The Centre for Rural Health was initially contracted by the Southern Regional Health Authority (SRHA) in 1994 to support rural health care teams. A number of models have been developed by the Centre team to accommodate the various areas of support. The main focus of the Centre has been to support the personal and professional wellbeing of the rural practitioners and their families who serve the rural communities. The philosophy which guides the Centre's work is to promote a stable workforce, working in collaboration with an empowered, committed and enthusiastic rural community with the aim of improving rural healthcare. This belief has led the Centre to focus its current direction and energy into undertaking a number of core rural research projects. The Centre secured funding for a further three years (1999-2002) from the Health Funding Authority (HFA). The HFA amalgamated the four regional Health Authorities into one organisation. One of the projects that I am currently working on is to find the "essential elements for successful rural teamwork" and to describe team effectiveness as it applies to rural health care teams. This project aims to identify how teamwork can be improved and to develop a structured education programme to foster collaborative teamwork. I conceptualised, and developed the proposal for the HFA and am currently the leader of this project.

My continuing interest in teamwork has led me to incorporate this topic within an interdisciplinary postgraduate paper as part of the Diploma of Primary Rural Health Care through the University of Otago. I was part of the team who put together this Diploma from its inception in 1997-98 and I am now a Lecturer and co-convener for the Diploma. One paper offered in the Diploma incorporates the theoretical and practical underpinnings of interdisciplinary teamwork in practice, at both community and personal levels, with a focus on rural health care. I developed and teach part of this paper.

During the past five years I have been invited by a number of government agencies to contribute to the many proposals and reports put forward to develop effective General Practice and primary health care services. One report in particular was Ministry of Health's "The Next Five Years in General Practice" (1995). My contributions have mainly revolved around how teamwork can be effective for the delivery of General Practice health provision.

Given my professional identity is as a registered nurse, situating myself as a researcher and critical social scientist within this study has been a challenge. In my case this was complicated by a sense of ambivalence about the ways in which I was simultaneously a nurse and a researcher. It has been essential that I have provided my views on teamwork and role and the issues that surround them. The reason for this has been to assist the reader to build up their own views and assumptions of my world view which I may have brought into this research. As a researcher I have respected the views and opinions of each of the participants. The participants came from two separate disciplines; nursing and medicine. Because of this I have had two research supervisors from New Zealand. Both of my

supervisors hold the positions of Head of Departments and are Professors; one of Nursing and the other of General Practice. My nursing supervisor was chosen because of her interest in critical social science. She is my main supervisor from Victoria University, Wellington, and New Zealand. My other supervisor has an interest in General Practice and teamwork and was the main researcher for the local research on teamwork undertaken in 1993 in Christchurch, New Zealand (Toop, Nuttal & Hodges 1996; Toop & Hodges 1996). Both supervisors play a different part in supervising my research journey. Having both a nurse and doctor as supervisors, with their different views and academic styles, has assisted my thinking and the design of this interdisciplinary research. It has been important for me to have the support, while undertaking this research, both from the nursing and medical professionals. This has assisted me in understanding the thinking and rationale which surrounds the medical discipline as well as nursing, and how they may relate to each other.

1.2 Structure of the Thesis

The research on which this study is based involves the utilisation of qualitative research strategies and has been informed by critical social science using Fay's (1987) critical framework. I set up the research in this way to increase the possibility of the participants gaining insight into the socially constructed understandings of their own and each other's roles for the delivery of General Practice services. Dialogue on understandings has been generated through discussion at facilitated focus group meetings, the method chosen to obtain the data for this research. Critical social science relies on taking account of the historical and current socio-political context of the participant's situation, and will be described in more detail in Chapter 2. Critical social science also provides a means to assist

the participants to search below the surface, make visible the invisible and expose the traditional roles which they may take for granted. This is covered in Chapter 3. By questioning those taken for granted assumptions that may have informed their understandings, it may be possible to identify the gaps, silences and ambiguities which the literature has identified as a barrier to full team collaboration. My aim has been to produce research findings and to extend current knowledge, which could be useful to practice nurses, general practitioners, and policy makers. This thesis set out to explore whether practice nurses and general practitioners do, in fact, understand their own and each other's roles for the provision of General Practice services. Chapter 4 covers the research design, while the analysis and my interpretation of the research data can be found in Chapter 5. This thesis also explores why the essential elements necessary for effective teamwork are not part of everyday practice. It challenges the assumptions about fixed ideas and stereotypical roles in relation to teamwork and the delivery of General Practice services. This research concludes in Chapter 6 by arguing that the results may advance understandings and knowledge of traditional roles of practice nurses and general practitioners. New understandings that emerge could lead to the development of alternative models of health delivery. I have developed a potentially suitable model to explain what I consider to be some of the essential elements for effective teamwork. This model is based on Maslow's (1954) self-actualisation hierarchy of the needs of individuals adapted for self-actualisation of a team. How this model may help in furthering our understandings of teamwork will also be highlighted.

CHAPTER 2
Understanding Teams in Relation to General Practice

2.1 Overview of Chapter

This chapter provides a descriptive account of the literature on why teams are important for the delivery of primary health care. This chapter includes a brief historical account of the developments of general practice teams and what are considered the essential ingredients for functional teams. While there are a number of benefits of teamwork there are equally a number of barriers. A descriptive account is provided relating in particular to the barriers of teamwork that are associated with the historical and professional development of practice nurses and general practitioners; the general practice environment as it relates to New Zealand and the context in which these practitioners are socialised. These barriers will be considered along with the essential ingredients which are thought necessary to ensure teams perform as efficiently as possible for the provision of today's health care.

2.2 Teamwork for Effective Primary Health Care

The underlying belief informing this research is that teamwork will benefit the delivery of general practice services by practice nurses and general practitioners. The importance of teamwork in the delivery of effective primary health care has received increased attention over the past decade. It has been well documented in the literature that the need for a team of health professionals is essential to provide effective primary health care (Isles & Auluck 1990; Waine 1992; Poulton & West 1993; Toop, Nuttall & Hodges 1996; Toop & Hodges 1996; Opie 1997; Elwyn-Jones, Rapport & Kinnersley 1998).

The following reasons are often quoted as to why a team approach is needed to address the complexity and variety of skills required to meet the individual and/or community's health needs. First, there has been a wider appreciation by health professionals, consumers and funders of the determinants of ill health than ever before. Second, there has been a tremendous emphasis placed on the public, both by health professionals and the government, to take more personal responsibility to achieve a healthy lifestyle. As the public takes more responsibility for their own health care, together with the health professionals they require more information and education to provide and assist them in making informed health care decisions. Third, the importance of providing cost effective health care has been given added impetus because the current cost containment culture of health care has put pressure on all professionals to work within a competitive climate (Hornblow 1997). The main objective of the health reforms was to provide a fairer distribution of health care within a cost containment strategy. The strategy was to produce a competitive market for health providers with rationing of funds and increased consumer participation in health care (Gunn 1997). These changes commenced with the Ministry of Health's (1998b) Health and Disability Act 1992. This Act was based on the assumption that health services would be delivered more effectively if the purchaser and provider were separated.

The health reforms changed the culture for the provision of health care from one of collaboration to competition (Blank, 1994; Hornblow 1997). Organisations and/or individual health professionals were at times put in a position of competition with each other to tender for the same health service contract. This approach for the provision of health care is clearly not conducive to collaboration or teamwork. Additionally, providers

of primary health care were no longer guaranteed traditional funding under the health reforms. Changing the system of funding to a competitive model (Hornblow 1997), allowed the Health Funding Authority (HFA) to contract with a number of different providers. This, in turn, increased the potential for duplication and fragmentation of health services (Toop 1998a).

It is my belief that the past decade of government reforms in New Zealand has led to a number of difficulties that impact on teamwork and primary health care. The health system reforms have effectively resulted in health professionals and health care groups being accountable to a number of different organisations with a variety of funding structures, each with their own goals and visions. In addition the independent contracting status and the differing employment status of general practitioners, practice nurses, and other primary health care providers has led to tensions within the health care team (Toop 1998a).

As teams are currently being promoted for effective and efficient delivery of primary health care, it is timely to give this topic some attention. The team approach is not a recent innovation. Teams have existed for a long time. In fact, Katzenbach and Smith (1993) state teams have existed for hundreds of years in many countries. Over the years teams have been developed and been applied to a number of areas in the health sector. These include child abuse (Martin cited in Duncanis & Golin 1979); chronic illness (Halsted cited in Duncanis & Golin 1979); community mental health (Lastof cited in Duncanis & Golin 1979) and rehabilitation (Wilson cited in Duncanis & Golin 1979). It was not until the 1940's that primary health care teams were organised by Martin Cherkosky at Montefire Hospital in the Bronx, New York (Duncanis & Golin 1979). The primary health care team

then spread to neighborhood health centres in the 1960's. It is not possible to state precisely when the concept of a team in the primary health care setting became a reality (Hasler 1992). However, according to British Medical Association cited in Elwyn- Jones, Rapport and Kinnersley (1998) the term primary health care teams emerged in the 1970's in Britain. This emergence can be associated with the development of the practice nurses working alongside a general practitioner.

Influenced by the British style, New Zealand also emerged with a similar delivery of general practice. The aim was that a team of different health professionals could provide many benefits for the provision of health care (Jefferys & Sachs 1983). The creation of a team of health professionals brings together different professions who can in theory provide a more complete health service. In my opinion, and from my experience, I believe teams are not a simple construct. They are often complicated, dynamic and potentially threatening to individual team members. Therefore, teams need to be understood and handled with care, respect and pride. It is the actual diversity of the various disciplines needed to provide effective and appropriate primary health care rather than their similarities which can cause unease between the team members. Teams have so much potential to offer and perhaps the essential elements, which make teams a success have not been fully explored.

> *There is much more to the wisdom of teams than we ever expected.*
> (Katzenbach & Smith 1993 p.12)

I intend to consider within this chapter the important elements which make up a functional team and relate these to the barriers associated with teams. My underlying belief is that

effective teamwork can improve the utilisation of resources, the quality of health care and productivity by health professionals.

2.3   Why Teams are Important

When people think of teams, they may conceptualise people in some kind of a group with a task to achieve. There is a general belief that a team can attend to the overall needs of a patient more effectively than individual health professionals can. There are a number of aspects of health teams that give them an advantage over individual professionals working separately. A team has the potential to share the responsibility from a single person to a group (Katzenbach & Smith 1993). Decisions, which are made in theory or learned, are by consensus and shared amongst its members. These shared responsibilities offer some protection in a climate of increasing legal and ethical scrutiny and support for each member. Teams who function effectively and efficiently have the ability to improve health services and reduce fragmentation of care (Williams & Laungani 1999) especially when they work within a defined population (Toop 1998a). Many important aspects of health care such as the management of chronic health, maternity, and elderly care, to name but a few, require effective teamwork and shared responsibility of care (Pritchard & Pritchard 1994; Elwyn-Jones, Rapport & Kinnersley 1998).

Although teams are being promoted as beneficial to provide health care there is a limited amount of available research literature on the positive effects of teamwork. This is particularly so within the general practice environment in New Zealand. To assist my

understanding of teams it has been necessary to take an extended look at the international literature to acquire a broader understanding of teamwork.

There are a number of research projects which demonstrate that innovation in teamwork can be linked with effective team collaboration as expressed by West and Wallace (1991). Research undertaken by Poulton and West (1999) on the requirements for team success could find no significant relationship between team structure and the four measures of team effectiveness that they identified as teamwork; organisational efficiency; health care practice; and patient centred care. They emphasise that team process which includes shared objectives; participation, emphasis on quality; and support for innovation were the best elements for successful teamwork. Teamwork encourages mutual respect and individual autonomy among professionals and support for each other requiring effective teamwork. Through teamwork, professionals can develop a greater awareness and understanding of the contribution of other team members and their personal attributes. Evidence suggests that these elements of teamwork, together with agreed goals, lead to increased team effectiveness (Guzzo & Shea, cited in West & Poulton 1997). Katzenbach and Smith (1993) argue that teamwork effectively ensures team performance. This is an area that will be discussed in chapter 6 as this research progresses.

However, in contrast to these positive views of teams, there are some who argue that teams waste time, hinder individual performance and risk the loss of hierarchical control (Katzenbach & Smith 1993). As there are numerous ideas and beliefs which surround teams and teamwork, it is appropriate to expand on the different meanings that are attached to these concepts. To help achieve this I have provided a number of definitions of teams.

The concept of a team has several core features and although the definitions have similarities they place different emphasis on the components of a team as follows:

2.3.1 Definitions of Teams

The Concise Oxford Dictionary Plus defines "team" as:

> *"Two or more beasts of burden harnessed together."*

or,

> *"A set of persons working together."*

<div align="right">(p.1337)</div>

Whereas Pritchard and Pritchard (1994) suggests that a team is:

> *A group of people who make different contributions towards*
> *the achievement of a common goal.*

<div align="right">(p.13)</div>

Katzenbach and Smith (1993) believe a team is a number of people who have a common purpose, collective goals and shared accountability and state, "teams are a powerful vehicle for performance." (p.43)

They further define teams as:

> *A small number of people with complementary skills who are*
> *committed to a common purpose, performance goals and*
> *approach for which they hold themselves mutually*
> *accountable.*

<div align="right">(p.43)</div>

The common themes that emerge from the definitions comprise some of the basic assumptions of teams, which fall into three areas as described by Colt (1998):

> *Team members have a shared understanding of roles, norms and values within the team. The team functions in an egalitarian, cooperative, interdependent manner. The combined effects of shared, cooperative decision making are of greater benefit to the patient than the individual effects of the disciplines on their own.*

(p. 851)

To summarise, it could be suggested that health teams are considered groups of health professionals from a variety of disciplines who understand and accept each others' complementary contributions to achieve common performance goals with shared responsibilities.

It has been suggested by Katzenbach and Smith (1993) that teamwork alone never makes a team. However, the components or values, which make up teamwork can encourage and assist teams to succeed. Teamwork requires a set of values which allow listening, responding and support. These values, if accepted by the members of the team, can assist in communication and collaboration which have been suggested by Katzenbach and Smith (1993) as essential ingredients for successful teams. Similarly, teamwork is defined as the actions, processes, and behaviours which contribute to a team's ability to achieve specific, shared, and valued objectives. These make up the structure and characteristics of a team and team structure.

2.3.2   The Structure & Characteristics of a Team

There are a number of structural distinctions between different types of teams. Teams may be classified in many ways. One such team may use the terms; *real, pseudo, potential and*

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high performance (Katzenbach & Smith 1993), while Pritchard and Pritchard (1994) describe teams as *intrinsic, functional, and full*. The *real* team as described by Katzebach and Smith (1993) is similar to the *intrinsic* team put forward by Pritchard & Pritchard (1994). This team works together day in and day out, closely integrated in the performance of special tasks. As the team works closely together, members develop a strong mutual understanding of each other's skills when they work in collaboration. It is believed these features can greatly enhance patient care. The *potential* (Katzebach & Smith 1993) or *functional* team (Pritchard & Pritchard 1994) is made up of the *real* or *intrinsic team* with additional members who join the team for specific functions only when their services are needed. As with the *real* team there is a similar need for team meetings, mutual respect and open discussion. The *pseudo* team is a team assembled for a particular patient and exists only for that patient (Katzebach & Smith 1993). Pritchard and Pritchard (1994) put forward the notion that the *full* team usually implements, or introduce, new services or plans. Whereas, the *high performance* team described by Katzebach and Smith (1993) indicates that the members of this team are committed to its success, and the encouragement and opportunity for individual members' personal development. This may achieve a positive impact and influence on the functioning of the team. A *functional* team encourages active, supportive participation from all of its team members. It promotes innovation; itself a success factor of *high performing* teams (Poulton & West 1999). All contributions need to be accepted without criticism as this encourages alternative ways of doing things. This approach, together with trust and mutual respect for all team members, encourages creative thinking and effective change (Haye 1997).

Ducanis and Golin (1979) have identified nine characteristics which make up a team. I have summarised these characteristics into the following. A team is comprised of at least two individuals; these individuals may either meet face to face or not meet at all (but communicate by alternative mediums); a team leader is always identifiable; teams function both within and between organisations; team members' roles are defined; collaboration is essential in teams; team guidelines are operationalised; and the team is patient centred and task orientated. West (1994) has identified that there are four main factors named the four-factor theory, which are interrelated and make up the characteristics of an effective team. These are team vision, participatory safety; support for innovation, and task orientation, which when worked simultaneously can lead to improved performance.

As this research is based within a General Practice environment it is necessary to consider General Practice in relation to the literature on teamwork, and the New Zealand social context.

2.4 Teamwork and General Practice in New Zealand

The structure of General Practice traditionally has been to provide the point of first contact quality, comprehensive, accessible, continuing and preventative health care. General Practice provides health care to individuals, families, whanau (all relations by blood, marriage and often friendship, a term associated with Maori people) and communities. In New Zealand the General Practice services are widely used by the majority of the population Ministry of Health's "Taking the Pulse" (1999). The continuing relationships which develop between patients and primary health providers allows for the building of

trust and a comprehensive knowledge of the patients' and the health of the families (Murtagh 1995) and whanau (Durie 1998).

The core General Practice primary health care team in New Zealand is generally comprised of practice nurses and general practitioners. For the purposes of this research this core general practice team has been utilised. The ideal is that teams have developed to provide a comprehensive range of health services for the needs of their target population utilising the combined skills and knowledge of both the general practitioners and practice nurses. However, we will see within this chapter, this is not always the case. There are a number of reasons, these include but are not limited to the considerable differences between the development of nursing and medicine for the delivery of community health care. Historically, in New Zealand General Practice doctors provided services and are known as general practitioners. Initially general practitioners worked as a solo practitioner (Louden 1983) in isolation out of their own surgery rooms or clinics (Hasler 1992). The general practitioner undertook the role as leader of general practice with assumed responsibility to the patient and the provision of care provided by other health care professionals. Up until the 1970's general practitioners had no formal attachments or relationships with other primary health care providers. Traditionally nurses worked independently of general practitioners within the community setting as district and public health nurses, generally visiting people in their own homes and workplace (Hasler 1968). The relationship between nurses and general practitioners was poor with little collaboration (Williams 2000).

The presence of nurses in general practice is a fairly recent event having been established over the previous twenty-five years in New Zealand. This took place in the 1970's when

practice nurses were first employed in the General Practice setting. The establishment of a practice nurse in New Zealand had two main objectives. First, it was thought the availability of a subsidised practice nurse might encourage general practitioners to practice in rural areas where there was a shortage of doctors. Second, it was anticipated that a nurse working alongside a general practitioner could assist in the more routine *medical* tasks. It was thought that the nurse could free up the general practitioners' time so they could practice medicine (Hasler 1992; Hounsell 1992; Collins 1996; Docherty 1997).

The role of practice nurses in New Zealand evolved with the introduction of the practice nurse subsidy scheme. However, at the evolutionary stage practice nurses themselves were not invited to develop their role, rather their role was prescribed by general practitioners (Collins 1996). Practice nurses have been described from the early days as "the doctor's assistant" (Collins 1996 p. 84). Their role has included a variety of skills, some nursing and some other tasks such as; office duties, reception work and cleaning (Hounsell 1992; Mortlock 1996). The way practice nurses have worked has been generally directed by the needs of the general practitioner rather than led by the needs of the community as indicated in the tasks above.

Today the range of practice nursing services varies from traditional nursing tasks to a more autonomous role. The role of practice nursing includes; assisting patients, teaching and implementing lifestyle changes, explaining and reinforcing instructions given by the doctor and carrying out a variety of treatments. Many practice nurses provide patients with the opportunity to consult with them directly (Docherty 1997).

> *Not so long ago the nurse was dispatched to the treatment*
> *room to do the dressings, the "shots" and the cleaning up but*
> *now she is more and more considered a full partner in the*
> *Health Care Team.*
>
> (Hample 1992 p. 31)

Despite the advances of the practice nurse role, Hounsell (1992), Docherty (1996; 1997) and Carryer, Dignam, Horsburgh, Hughes and Martin (1999) express their disillusionment. Many practice nurses remain under utilised, desire more autonomy (Docherty 1997) and are described as being invisible in General Practice (Mortlock 1996). The Ministry of Health's Report on the "Ministerial Taskforce on Nursing- redressing the potential of nursing" (1998a) noted practice nurses frequently were unable to contribute as full and equal team member because they had limited access to resources. The resources mentioned included being unable to claim a fee for service subsidies, unable to refer to other agencies, and having no authority to use diagnostic services. Many also had limited physical workspace and had a potentially strained employer/employee relationship with the general practitioner. Mortlock (1996) challenges the assumptions about the nature of what has been the subordination of nurses in relation to the employing doctors. The barriers which affect the practice nurse's role, if not challenged, will keep this practitioner as one of assistant to the general practitioner, which according to Carryer et al (1999) precludes collaboration and the appropriate utilisation of nurses for community health care.

However, if practice nurses were able to define their own parameters of practice in response to local community needs and not have their role extensively defined by the general practitioner, arguably they could more fully complement the care provided by that of the general practitioner (Docherty 1997). Roles which complement each other, are in line with the principles of teamwork benefiting both patients and general practice.

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Despite the historical issues over the development of practice nursing, practice nurses have demonstrated energy and commitment to developing their specialty. Hounsell (1992) describes how practice nurses, because of the geographical isolation, employment status and their relative new profession identity, have grouped together and become a progressive group. The grouping of practice nurses from an early stage assisted them to become innovative (Hounsell 1992; Newland 1998) and take responsibility for their own continuing education and expansion of their roles (Collins 1996; Mortlock 1996). I believe practice nurses are poised to fill a much greater role which is opening up within primary health care. They do after all represent the largest group of community nurses in New Zealand (Dunn 2000) and in 1999 the Practice Nurse Section of the New Zealand Nurses' Organisation (NZNO) received college status and became the first College of Practice Nurses NZNO.

The development of a functional General Practice team has raised more concerns than was anticipated in the 1970's (Toop, Nuttall & Hodges 1996; Toop & Hodges 1996). It was at this time that the two separate disciplines came to work together. This provided an opportunity for practice nurses and general practitioners to work within an interdisciplinary team model for the first time. They were able to share the workload of general practice, thus setting in place the potential beginnings of a team. However, to date, the model of a variety of disciplines working together in the form of a primary health care team has been slow to develop (Opie 1997). In my opinion, General Practice teams have not been developed and planned effectively. They have developed with an ad hoc approach which may have contributed to the lack of effective teams and teamwork. There is clearly a gap between the actual and desired levels of collaboration as indicated by Toop, Nuttall and Hodges (1996) and Toop and Hodges (1996).

When the members of the general practice team came together in the early 1970's there was little literature available about the requirements necessary to develop functional teams. Toady we have a better understanding of what makes teamwork and it is to this literature I turn and provide an overview of what has been suggested as the requirements for effective teamwork.

2.5   Principles for Effective Teams - The Essential Ingredients

According to Katzenbach and Smith (1993) there is a basic recipe, which includes a number of essential elements for effective teamwork. If followed, these may improve the performance as described in the following quote.

> *Groups become teams through disciplined action.   They shape a common purpose, agree on performance goals, define a common working approach, develop high levels of complementary skills, and hold themselves mutually accountable for results. And, as with any effective discipline, they never stop doing any of these things.*

(p.24)

The essential ingredients include agreement (by a number of researchers mentioned previously) on team performance; team goals and tasks; collaboration and communication; and understanding individual roles and function. These four ingredients will now be discussed in turn.

2.5.1   Team Performance

It has been suggested performance is the primary objective of teams and that no team arises without performance goals. Performance goals are an integral part of team development.

To focus on performance requires the setting of clear team goals with built in performance outcomes. Each team member must be clear about their own and each other's contributions. The tasks performed need to be interesting, engaging and challenging. Interesting tasks engender commitment, motivation and cooperation in team members challenging (Guzzo & Shea 1992 cited in West & Poulton 1997). If a team takes on a task then the whole team must take the responsibility if things go wrong, and likewise take joint credit for successes. Measurement of a team's performance can be done in a number of ways. First, this can be achieved through peer review of the team's work. More recently measurement of performance is being achieved through clinical audit, outcome measures and the development of standards and guidelines. Team performance influences team effectiveness which requires utilisation of the appropriate skills of all members of the team (Guzzo & Shea cited in West & Poulton 1997).

2.5.2 *Team Goals and Tasks*

Team goals give direction to the team's actions. Goals can be divided into two types; end goals and process goals as indicated by Katzenbach and Smith (1993). End goals are defined in terms of an external target whereas process goals are to be found within the process of teamwork. The team members can relate to the way they work and their progress which is entirely within their control. It is worth setting both types of goals. As health professionals set and meet their process goals then it is probable they will also, if they are not too unlucky, reach their end goals. If however, the focus is only on the end goal, and not on the small process steps and the end goal is never reached, failure and disappointment can be more devastating for team members (Katzenbach & Smith 1993). Teams who have clear goals and know how they are going to achieve those goals, define roles and have a

plan to develop team focus and direction (West & Wallace 1991). The failure of a team to set clear goals often contributes to their lack of performance (Katzenbach & Smith 1993).

Clark (1984) states it is vital for effective team function that all team members understand and accept team purposes and goals. Membership, participation and decision making regarding the function of a team, will result in commitment to the identified goals. The criteria for effective goals should be positively framed, achievable, measurable and accepted by all team members. shared aims of a team, no matter how important they are, will not occur without strategic planning, negotiation between team members and hard work. Advice provided by Katzenbach and Smith (1993) suggest that goals should not be put into action before there is joint team members' agreement. This aspect of teamwork is often missing because team members realise there could be disagreement and would rather not get into conflict situations with other colleagues. This may be one of the reasons they omit to discuss and negotiate goals. It is, however, better to discuss team goals prior to undertaking the tasks to avoid irretrievable conflict. This can be achieved by effective collaboration and communication (as described below), another essential ingredient for effective team and teamwork.

2.5.3   Collaboration & Communication

Open communication cannot take place when there is pressure to conform to the majority decision. Differences of opinion are healthy and to be expected, while developing group strategies for conflict resolution. Conflict within a team according to Ross (1989) is inevitable and a normal part of any team's process. It is therefore necessary to acknowledge conflict and develop appropriate agreed ways of resolving it prior to the situation arising. If

this is accepted it will encourage open effective communication which will assist in the team performance and in the necessary negotiation of roles and tasks.

Understanding roles within teams has been repeatedly identified in the literature as a prerequisite for effective teamwork (Isles & Auluck 1990; Poulton & West 1993; Toop, Nuttall & Hodges 1996; Toop & Hodges 1996). It has been suggested that if roles are not understood by team members this can be a barrier to effective teamwork.

As described previously, the aim of this research was to explore whether practice nurses and general practitioners did in fact understand each others' roles. Ducanis and Golin (1979) indicate that gaining insights into role expectations is an important step towards achieving "role clarity" an essential ingredient for effective teamwork (Meleis 1975). Role clarity includes understanding the goals of the role, developing the behaviour and attitude necessary for goal achievement and identifying role boundaries. For this to be successful there should be a high level of awareness among the team members who need to be sufficiently focused on their own and each others' roles and responsibilities (Williams & Laungani 1999).

2.5.4 Roles & Functions

In order for roles and functions to be effective team members are required to recognise their own contribution and work as a collaborative team. If the members of the team do not do this the performance of the team may be reduced which ultimately may effect the delivery of primary health care services. Hence the importance of understanding ones own and each other's role and contribution for the setting of team goals. In my opinion and experience,

the acceptance and understanding of roles is not as simple as suggested in the literature. This position will become clearer after describing the original meaning of role and social role. I believe the description of the social role has a major impact on individual and collective functioning, behaviour, beliefs and attitudes for teams and teamwork.

2.6 Perception of Individual and Collective Team Roles

2.6.1 *Historical Understanding of Role*

The meaning of role originated from the French word "la rolle" derived from the Latin "rotula" which meant a little wheel or round log (Lindzey & Aronson 1968). It later took on the meaning of formal papers such as the "rolls" of Parliament whereas in classical times the parts in the theatre were written on "rolls". It was this latter meaning which re-emerged with the development of the modern stage and an understanding of a role-played by an actor. The role came with an expected (by the audience) set of behavior that a particular character would perform. However, it was not until the 1930's the word became used more precisely by sociologists to refer to the expected behavior of a person in a given social situation (Biddle & Thomas 1966; Lindzey & Aronson 1968).

2.6.2 *The Construction of Role as Understood within Society*

Role can be used to label a group of individuals who possess certain characteristics which they have in common (Downie 1971). There are many and varied definitions of "role" but "a generally accepted one is that role constitutes the behavior expected of an individual by virtue of his occupying a specified position in a social situation" (Gilmore, Bruce & Hunt 1976 p. 9). The behavior, actions, values and beliefs of the individual in this role is

prescribed and judged by society, professions and individuals. Role is also associated with social status requiring certain rights and obligations, and can refer to a person's social position in society. The underlying assumptions and expectations behind established and stereotypical roles quickly became entrenched and difficult to shift. Hence the general practitioners' assumed traditional role as "leader" of the general practice team, and the practice nurses' role as "assistant". Roles in a team can be associated with professions or a position within an organisation. Both role and status are linked to social power or to the power of the organisation (Ducanis & Golin 1979). Power, in this sense, can be beneficial for some members of the team. However, if this is not projected as a positive force then this can have a negative or oppressive impact on the other members of the team. If we reflect back to the principles of teamwork, which places an emphasis on collaboration and valuing individuals' contributions, then the elements of power, if used in a negative way, could in fact be a disadvantage for the team's performance.

I believe all members of a team are equal. Each person's contribution is necessary for effective team performance. Effective teams require a mix of skills and therefore all members of the team have to agree on the skills and experience allotted to other members. In today's climate of changing expectations of health provision, consumers, funders and practitioner, professional roles may became blurred and uncertain (Pritchard & Pritchard 1994). It is important to accept that some roles or skills associated with the team are unique to one discipline while others overlap into other disciplines. This can cause confusion and "turf guarding" within disciplines. I believe it is best for roles and tasks to be negotiated with skills assessed amongst the team members on the basis of competency rather than on the basis of assumptions guided by traditional stereotypes of a specific discipline.

2.7 Teamwork and the Functioning of Team Members

Various Government documents and reports (Health Funding Authority's Report on "The Next Five Years in General Practice" 1998; Ministry of Health's "The Future Shape of Primary Health Care 2000a; New Zealand Health Strategy 2000b and the Summary of Responses to the Future Shape of Primary Health Care 2000c) all highlight the positive influence of teamwork for the delivery of health. A number of barriers are identified which inhibit effective and efficient health delivery by teams (West & Slater 1996; Toop & Hodges 1996; Opie 1997; Elwyn-Jones, Rapport, & Kinnersley 1998). Opie (1997) explains that much of the literature on teamwork in the health care setting has been demonstrated as anecdotal, exhortatory and prescriptive. At the same time the literature has questioned whether teams can function efficiently (Ducanis & Golin 1979; Ovretrivit 1990; Isles & Auluck 1990; Waine 1992; Poulton & West 1993; Katzenbach & Smith 1993; West & Slater 1996; Opie 1997; Toop, Nuttall & Hodges 1996; Toop & Hodges 1996; Elwyn-Jones, Rapport, & Kinnersley 1998) as there appears to be a substantial gap between theory, practice, reality and expectation.

A New Zealand survey which was undertaken in 1993 in Christchurch, New Zealand, explored the local barriers to successful primary health care team collaboration (Toop & Hodges 1996 ; Toop, Nuttall & Hodges 1996). It is evident from this research that a gap between actual and desired levels of collaboration existed. The barriers described by the groups of primary health care professionals included; insufficient time for effective communication with team members; difficulty in providing fully integrated care unless the team was caring for the same patients; the negative attitudes of other disciplines; confusion

about interdisciplinary roles; the lack of value placed on the contribution provided by each member. In addition, a number of barriers have been identified, by Ducanis and Golin (1979), who suggest too many members in a team represents a disadvantage for effective teamwork. As the team increases in size the possibility for relationship conflict between members increases (Pritchard & Pritchard 1994). Equally the potential also exists that the skill base will also increase and that individual contributions may be diluted by more forceful members (Ducanis & Golin 1979). Pritchard and Pritchard (1994) and Poulton (1995) have suggested that the optimum size of a successful team is between eight and ten members. A small team helps to build trust amongst its members and increased awareness of each others' contribution and role.

A study by McClure (1984) described problems associated with team members' communication. This was confined to patient issues rather than setting team goals. Armstrong, Taverbie and Johnston (1994) voiced their concern in their study that practice nurses were involved more in task substitution than in teamwork. Wiles and Robinson (1994) have similar findings and state:

> *Attempts to change attitudes within the primary health care team in an effort to produce greater democratic teamwork appear to bring only limited change. It seems likely that significant change will only be achieved if the circumstances under which the professionals work change in ways that elevate their status*

(p.330)

The effect of outside pressures on the performance of team members and teams can be contradictory. In particular the perverse incentives inherent in the funding of General Practice services, and the traditional working relationships with other disciplines, in

particular, the relationship between nurse and doctor. These barriers will now be described under the following headings.

2.8   Barriers to Teamwork as Related to General Practice

There are a multitude of barriers which appear to inhibit the success of teamwork. It could be argued that even in the event of one barrier being removed there still persists perceived problems to the access of patient care. Therefore, I consider it is beneficial to look at a number of identified barriers to teamwork. These include the professional working relationships between practice nurses and general practitioners based on traditional hierarchy which may lead to conflict; the employment of practice nurses by general practitioners; and the funding of General Practice services. These three areas will now be discussed in turn.

2.8.1   Conflict between Practice Nurses and General Practitioners

The history of the development of the role of the general practitioner has been long standing and their position in the delivery of health care and the development of their role is different to that of the practice nurses. I believe this has important implications for today's effective teamwork.

There is a widespread perception suggested by Sims (1986); Fried and Leatt (1986) and Sheppard (1986) that some doctors feel they own patients and see other health professionals as subsidiary. This can led to professional rivalry and jealously, neither of which are conducive to teamwork. They argue those professional assumptions and funding of the

general practice system (which will be discussed next) has kept people apart, thereby causing further conflict between professionals (Williams 2000). These moves, combined with incentives for general practitioners to enter a culture of financial management rather than being solely responsible for the care of patients, has shifted the boundaries for the provision of health care. This can create conflict for the general practitioner and other team members.

Unlike practice nurses, who have recently formed a specialist nursing group in New Zealand (Docherty 1996), general practitioners evolved in Europe from the apothecaries, the surgeons and the men/midwives of the late 18th century. The following quote by Loudon (1983) describes the variety and complexity of the medical role:

> *There was not one medical profession, but three: the physician, members of a learned profession with a background of university education who dealt with internal disorders; the surgeons, who were craftsmen whose sphere was external disorders and any conditions requiring manual interference; and finally the tradesmen apothecary, whose legal role was to dispense the physician-prescription.*

(p. 14)

It was in the 19th century that the specialisation of the general practitioner was established in Europe and North America (McWhinney 1989; Loudon 1983). It was also at this time that specialisation became evident in a number of other sciences, including medicine. The specialisation of medicine placed enormous value and emphasis on the importance of the mastery of technology and research in the area of surgery. The specialisation of medicine in this area influenced the developmental role and future of the general practitioner. The historical development indicates that the general practitioner was quite different from other physicians and surgeons (Williams 2000). The differences lay in their practice, which

included medicine, surgery, obstetrics and pharmacy. The doctors became out of necessity generalist practitioners. The relationship general practitioners developed with patients involved continuity rather than the episodic care of their surgeon colleagues. The general practitioner was in a position to adopt an holistic overview of health care rather then being centred on illness (McWhinney 1989; Williams 2000). However, the general practitioner's journey has not been an easy one. They have had to (and continue to) struggle for recognition and status to keep their specialty alive. This struggle has resulted in a difficult and intense period in the medical profession, which lasted throughout the second half of the 19th century and continues to some extent today.

The ability of a general practitioner to specialise in a generalist field continued its difficult journey into the 20th century. This was when all forms of general medicine became unpopular as careers for doctors. Students of medicine generally aimed for specialist skills to become hospital consultants. This trend resulted in a decline and saw the number of general practitioners in the 1930's drop. Despite a difficult journey the general practitioner today has a well, defined role and a set of skills which is necessary to delivery effective general practice health care (McWhinney 1989). The general practitioner is a well established professional who appears to have a degree of professional autonomy, and voice, and a degree of power which can influence the political scene (Williams 2000).

The second important factor is that practice nurses are employed by general practitioners (through part subsidy) while general practitioners are, themselves, self-employed small business owners/operators. It is to this barrier we will now turn.

2.8.2 *Employment of Practice Nurses*

An overview of the establishment of the practice nurse subsidy scheme is necessary for a better understanding of the complex relationship that has developed between practice nurses and general practitioners in New Zealand. In 1968 a Working Party recommended to the then National Government (McLennen 1984) the benefits of providing a subsidy, worth fifty percent, to general practitioners towards the salary cost of a practice nurse. The recommendations of the development of a subsidised practice nurse became a reality in 1970 with the establishment of the Practice Nurse Subsidy Scheme. The establishment of this scheme was confrontational between the New Zealand Medical Association (NZMA) and the New Zealand Nurses' Association (NZNA). The Medical Association at this time was a powerful group who lobbied and controlled the mechanics of this scheme. Consultation with nurses was minimal or non-existent (Salmond 1977, cited in Collins 1996). This led to a verbal battle between NZNA and the NZMA. The Practice Nurse Subsidy Scheme was initially rejected by the NZNA because of lack of consultation with nurses. However, despite this the NZMA indicated their wish to continue with the employment of a subsidised assistant even if it meant the employment of "non nursing personnel to whom they would teach nursing and semi medical skills" (Collins 1996 p.85). This was not acceptable to the NZNA who suggested the setting up of a committee (Practice Nurse Subsidy Scheme Committee) to look at the controversial issues, which were surrounding this debate. This initiative was accepted by the NZMA and a committee was set up with equal representatives from the NZMA and the NZNA to work through the issues (Burton 1970, cited in Collins 1996). This led to the development of the Practice Nurse Subsidy Scheme which in 1970 offered employment to the first practice nurse in New Zealand (Docherty 1996)

2.8.3 Practice Nurse Subsidy

Initially the practice nurse subsidy was set up to provide a subsidised nurse to assist general practitioners in rural areas. The subsidy was worth fifty percent of the nurses' salary payable from the Health Benefits the remainder of the salary being payable by the general practitioner. As the developments of practice nurses continued in the rural areas there was an increasing demand for this assistant to be made available to urban general practitioner (Brown cited in Collins 1996). In 1974 the practice nurse subsidy scheme was extended to include only urban solo general practitioners. At this time the practice nurse subsidy was increased from fifty to one hundred percent of the salary of a practice nurse (McLennen 1984). However, it was not until 1977 the subsidy for practice nurses was made available for group general practitioners throughout New Zealand, resulting in the widespread employment of practice nurses in general practice. Also in 1977 the number of hours payable under the Scheme for a practice nurse, increased from thirty to forty hours per week (Collins 1996). The subsidy was made available through Health Benefits for the services provided by practice nurses. While it was not the responsibility of Health Benefits for the practice nurse's employment as this rested with the individual general practitioner, Health Benefits did lay down a number of conditions of employment. The conditions clearly defined the principles for the use of the practice nurse subsidy scheme.

A number of years passed before there was any further threat to the Practice Nurse Subsidy Scheme when, in 1986, the subsidy was reduced from one hundred to seventy five percent. There appeared to be no firm evidence as to why this occurred. In 1992 there was a further change in the practice nurse subsidy scheme (Health Benefits' letter number 2) as discussed by Docherty (1996). These changes reduced the entitled number of practice nurse subsidy

hours (which had been increased in 1977) payable from forty hours per week, per full time equivalent general practitioner to thirty hours. In addition, a number of other allowances previously paid were withdrawn, for example; study leave, car allowance and practice nurse reliever payments (Docherty 1996). The requirement of a general practitioner to employ a receptionist for a minimum of twenty-five hours a week in order to qualify for the subsidy was also lifted. This new scheme required the practice nurse to sign a declaration on each subsidy claim (every two weeks) which stated their role was in agreement with the Regional Health Authority/s policy and the practice nurses' own individual job description. The numerous changes that have taken place to the practice nurse subsidy scheme continue today, and in 1999 yet another set of changes took place. Practices funded through a fee-for service had the number of hours a general practitioner could claim for the subsidy reduced from thirty to twenty-seven hours per week. These changes were a result of the recent Accident Compensation Corporation (ACC) changes which allowed practice nurses to register as an ACC provider and payment for the nursing services can be claimed from ACC (Kai Tiaki 1999).

The changes to the practice nurse subsidy (described above) have not been beneficial for the professional development or the sustainability of the specialty of practice nursing (Carryer et al 1999). There has been little chance for practice nurses to widen their scope of practice (Hounsell 1992) especially in light of the many practice nurse subsidy changes. A 1997 review of the way practice nurses were introduced into general practice has had a profound affect on how they work today (Carryer et al 1999). The conditions of employment and wages for practice nurses have been problematic (Hounsell 1992; Williams 2000). If there had been strings attached to the subsidy requiring the team to show

evidence of complimentary roles and more decision making then the collaborative relationship might be a little further ahead than it is today.

The employment of practice nurses is one contributing factor that is reducing the benefits of teamwork, goal setting and effective communication. The employment of practice nurses by general practitioners has been dependent on the continuation of the practice nurse subsidy scheme. Like many government subsidies it has not kept pace with inflation. Today the practice nurse subsidy represents only half of the salary of a practice nurse with no additional allowances included for illness, annual leave and study costs. The general practitioner or practice nurse pays these additional expenses themselves. The practice nurse scheme has not been straightforward and has contributed to the current unrest between general practitioners, practice nurses and the funding bodies (Docherty 1996). This has had, and continues to have, the potential to divide the general practitioners and the practice nurses.

2.8.4 Funding for General Practice

There are a number of concerns surrounding the funding of general practice which could be contributing to the barriers of teamwork. These include separate lines of control and different payment systems according to discipline rather than services. This in turn can lead to suspicion over motives, diverse objectives, professional barriers and perceived inequalities in status (Ministry of Health's Report of the "Ministerial Taskforce on Nursing- redressing the potential of nursing" 1998; Carryer et al 1999).

General practice is funded a number of ways. Every patient over the age of six years old pays a "fee for service" at the time of consultation. This payment may be subsidised by the government. General Medical Services (GMS) subsidies are targeted to certain groups. There is a full subsidy payable for consultations to the under six year olds, and a reduced subsidy for other groups. The subsidy is dependent on the income of the family which entitles them, if they are below a certain salary threshold, to a community services card. Adults without a card attract no government subsidy, and therefore pay the full fee for the service. The total fee is set by individual practitioners and varies considerably. Payment of GMS subsidies at this time are payable only to general practitioners. This part subsidy is available either as a fee for service or on a capitated basis. There are additional subsidies available from ACC (payable for services provided by the health practitioner and in the case of ACC registered practice nurses the payment is payable to the general practitioner only), insurance companies and for maternity care (also available to independent midwives). GMS fee for service funding provided to general practitioners is only available following a face to face consultation with eligible patients. No payment is available for a nurse consultation unless the general practitioner also sees the patient at the same time. This practice has major implications for the autonomous role of the practice nurse and scope of practice (Carson 1998; Toop 1998a). Practice nurse consultations are not eligible for GMS payments. Practice nurses may charge fees for the services they provide. However, these fees are usually small in comparison to the general practitioners' fees even though they may both provide the same service to the patient.

There are a number of conflicting issues relating to funding general practitioners to provide what is supposedly to be a team responsibility to deliver primary health care services. I

have identified two which impact on the delivery of General Practice in New Zealand. New Zealand is not alone with these barriers to teamwork and resolving one barrier may in fact uncover a multitude of other barriers. In Britain there is a financial incentives for general practitioners (who, as in the New Zealand system, employ practice nurses) to delegate as much work as possible to the practice nurse rather than undertaking the work themselves. This is because the funding for general practice services are directed for the service provided rather than to a specific discipline (which is not the case in New Zealand). However, in Britain there are still a number of barriers for effective team functioning despite the difference in the funding and delivery of services (Elwyn-Jones, Rapport & Kinnersley 1998).

Capitation, or population based funding, is a funding system from the government based on or affiliated to the population the General Practice serves. This funding model requires patients to be enrolled (Toop 1998b) with the general practice. The amount of funding received depends not only on the number of patients but also on the distribution of their ages and demography of patients eligible for a subsidy (Ministry of Health's New Zealand Health Strategy - discussion document 2000b). It is a system which aims for equity of access and a control on the growth of referred services of both acute and chronic admissions to hospital (Malcolm, no date). Potential disadvantages of capitation systems are that it makes it difficult for patients to move between general practitioners.

The advantages of capitation funding are that it provides general practitioners with a fixed annual income. The funding, to some extent, encourages the delivery of population health care and health promotion, and continuity of care to the patient population (Toop 1998b).

General practitioners throughout New Zealand have been slow to take up this opportunity to become capitated despite its emphasis in a number of government policy documents (Health Funding Authority's "The Next Five Years in General Practice" 1998; Ministry of Health's "The Future Shape of Primary Health Care" 2000a; New Zealand Health Strategy-discussion document 2000b)

Capitated funding provides flexibility of consultations, as it is not necessary for the general practitioner to see each patient at every visit in order to gain the government funding (as is the case with the GMS fee for service funding system). Under the capitated funding system patients still pay a fee for service which is graduated on the basis of age and income. This flexibility provides the practice nurse with an opportunity to work alongside the general practitioner in a more autonomous role, complementing the general practitioner and avoiding duplication and fragmentation of health services. The capitation scheme has assisted in the development of more integrated primary health care teams (Carson 1998).

> *The model of general practitioners working alongside appropriately trained and skilled nurses, respectful of each other's discipline and level of expertise, would, I believe, be in everybody's interest.*
>
> (Toop 1998a p.36)

The capitation funding system has enabled practice nurses to be part of the decision making process in general practice. Likewise, Newland (1998) implies that one advantage of a capitation system is that it assists practice nurses to run independent health clinics, in the management of asthma, diabetes and enuresis, to name but a few. Nurses within the Otematata Health Centre in Tauranga, manage patients with chronic illness who are visited in their own homes. The care is coordinated between the community and hospital by the

nurses. Additionally the capitation system has assisted union health clinics and a number of providers serving Maori populations (Malcolm no date).

A practice nurse in a position to partially utilise the services provides Capitated general practices. I indicate partially because there could be a number of other barriers which prevent this from occurring. Traditionally patients may rather see the doctor than the nurse. On the other hand practice nurses may traditionally expect the doctor to see the patient while the doctor may never expect patients should be seen by the nurse.

The conditions of employment of practice nurses and the current funding of General Practice are problematic. This is in addition to the recommendations set out in 1970 by the New Zealand Medical Association (NZMA) who suggested that no fees should be charged to patients for the services provided by the practice nurse (McLennen 1984). This could have been based on the assumption that patients did not generally pay for the services provided by nurses and/or that the nurse's salary was, at that time, fully subsidised by the government. The full potential of practice nurses' contribution to primary health care is not currently being met by society. This could be a result of the traditional funding structure and the practice nurse subsidy scheme (Carryer et al 1999). Whilst Loughlan (1992) indicates that changes to the government subsidy for the practice nurse and funding to general practice would alter the way practice nurses and general practitioners work together as an efficient team.

It could be argued that the health reforms in New Zealand have placed general practitioners in key positions, which are pivotal in the health market for the provision of health care. The

health reforms under the previous National government have supported innovative models of health delivery. These models have influenced the delivery of traditional health care. A number of models to date have been developed. These include Iwi health providers and other independent groups, for example, Independent Practitioner Associations (IPAs) (Malcolm, Wright & Barnett 1999). Groups of general practitioners holding large budgets for referral services have developed in recent years (Coster & McAvoy 1996; Hornblow 1997). IPAs are currently the main contractors with the HFA for General Practice services.

There are a total of twenty-one IPAs in New Zealand (to date). Of these twenty-one, five IPAs have extended an invitation to nurses, and an even smaller number of IPAs have included membership to other health professionals. One IPA in New Zealand is based within a community model of ownership. IPA membership places general practitioners apart from other primary health care providers as discussed previously which has been of concern to many health professionals. Barnett (research in progress cited in Malcolm, Wright & Barnett 1999) discusses the motivation for general practitioners to join IPAs who suggests IPAs stemmed from three main areas. First that of professional security for general practice services to have a single united contract (per IPA) for the provision of health care (Simon 1996; Majeed & Malcolm 1999; Malcolm, Wright & Barnett 1999). Second, to establish integrated care for the improvement of general practitioner's morale. Third, the HFA wanted to have larger funding contracts for the services general practitioners provided. They sought to encourage general practitioners to group together rather than continue with individual contracts.

It would appear there is a dissonance between general practitioners and other primary health care providers. This dissonance is in opposition with the philosophy of teamwork and the principles underlying primary health care especially when general practitioners have been encouraged to develop contractual groups (IPAs) which are excluding other primary health care providers. (The literature uses Primary Care Organisations (PCO's) interchangeably with IPAs):

> *some PCOs are regarded with uncertainty and suspicion by other primary care providers who are concerned by the growth of dominant general practice organisations and perceive threats to roles which other providers have traditionally exercised or are seeking"*
>
> (Malcolm, Wright & Barnett 1999 p.58)

If this is the case then how can other health care providers became part of IPA's or PCO's and contribute to the delivery of primary health care? The main goals of IPA's are to achieve better health outcomes for patients, to make better use of primary care resources, and maintain professional values (Malcolm 1998). IPAs have been successful in contracting with the HFA and have set a vision of health care delivery. The additional services include health promotion, screening, education of professionals, joint ventures with Maori, consumers and communities to name but a few. In some areas these services have developed from IPA savings derived from pharmaceuticals and laboratory tests. Savings are expected by the funds if the health practitioner becomes better informed of the cost of laboratory tests and prescribing of medications. This may led to adapting their management in particularly of clinical conditions (Coster 1997). To make savings usually requires either re-education of practitioners' clinical practice or the management and treatment of health conditions (Toop 1998b). The availability of ongoing education and small discussion groups for clinical practitioners has been provided in a number of ways. These have been

suggested by Coster (1997) and Richards (2000 WONCA Asia Pacific Conference Presentation 2000). They indicate that educational peer review groups discuss evidence based clinical practice specific for the clinical practice of general practitioners and practice nurses. This mode of education has been suggested as being the most appropriate programme for change in clinical behavior and management. There is some evidence that this approach has resulted in savings and improvement of health care within the general practice setting. In addition, a number of IPAs provide ongoing professional development for both general practitioners and practice nurses (Frost & Maw 2000 WONCA Asia Pacific conference presentation) . However, both practice nurses and general practitioners have indicated there is a need for improved understanding of teamwork for the effective delivery of general practice services.

2.9   Conclusion of Chapter

This chapter has put forward the argument that the promotion of teamwork is the most effective way of providing health care in the General Practice setting. Likewise, the principles underpinning this can have benefits within the General Practice environment. A detailed account has been provided from the literature which has discussed the benefits, barriers and the essential ingredients required for teamwork. Barriers associated with teamwork have been related to the New Zealand General Practice context. They were included to demonstrate the possible detrimental influences of the historical, professional and socialisation developments on practice nurses and general practitioners teamwork. One barrier identified in the literature is that team members need to understand each other's roles. Role has become a focal point of this research. The way role has been constructed

within society was also discussed within this chapter. Role and the elements associated with it such as behavior, values and beliefs are social constructions. Society expects individuals to perform those elements. It has been put forward by some social scientists that individuals can become oppressed and exist in a false consciousness because the social factors and political conditions in which they live determine their behavior. This theoretical position discussed next in Chapter 3 is known as critical social science.

CHAPTER 3
Placing this Research within A Critical Social Theory

3.1   Overview of Chapter

The aim of this chapter is to provide a brief description of the historical development and utilisation of critical social science. The chapter will also introduce Fay's (1987) critical social theory. I have chosen this particular framework to guide my research journey and to help me interpret the data as it assists in the critique of the social construction of roles. I include a detailed description of Fay's theory and how I have conceptualised and used it to interpret this data.

3.2   Theoretical Perspective

Critical social science developed out of the philosophical and scientific traditions of Hegel Marx, Pepper and Wittgenstein (Criab 1992; Allen, Benner & Diekelman cited in Ray 1992) and was refined in the 1920's by Habermas and his colleagues. These theorists worked from the Frankfurt Institute for Social Research (Criab 1992). They reasoned there was a need to develop new social research methods because science at that time was describing and researching society in a largely technical way. Critical social science was seen as a way of highlighting the oppression of the working class (Manis & Street 2000). At this time the social world had become an "electric monster feeding its own members, manipulating and absorbing any resistance that may be offered" (Criab 1992 p.208). The Frankfurt theorists were concerned with the way aspects of society were being manipulated

and forced into the dominant discourse's beliefs. Habermas and his colleagues were concerned that the human aspects of the social world were threatened by technical science. They wished to uncover the fundamental elements of social thought, values and judgement. It was their belief that these fundamental elements could be integrated into a critical theoretical framework, which focused on the practical environment in which it was placed. However, it was not until the 1960's and 1970's that the political activists and "radical academics" who utilised the fundamental concepts of this science (Criab 1992 p.223) adopted critical social science. In Criab's view, critical social science did not emerge until this time because it was too abstract and generalised. More recently nurse researchers have recognised the need for in-depth analysis which provides an extended social understanding and direction for their practice (Cody 1998). According to Ray (1992) and Henderson (1995), nurses are "exploring the use of emancipatory inquiry, particularly feminist and critical theories, as philosophic bases for nursing practice and research" (Henderson 1995 p.58). In particular, nurses are interested in the dynamics of nursing within the socio-political contexts of where people live and work. Nurse researchers are turning to a method of analysis which can assist them in an appropriate way. This will now be discussed.

3.3   Nursing & Critical Social Science

Ray (1992) states nurse researchers are turning to critical social science in an attempt to gain in-depth understanding of the dynamics of the contemporary human condition of nursing within the socio-political contexts in which they work. Socio-political contexts need to be understood while taking into consideration the health care reforms, power structure, health care funding, and oppressive features of society.

Kim and Holter (1995) has suggested that a critical social science framework can assist both clients and nurses for the delivery of health care. They imply, "nursing practice with this focus can then be considered a human-to-human service with a view of clients, not as clinical events, but as experiencing and communicating persons"(p. 216). Stevens and Hall (1992) suggest nurses, particularly in primary health care, need to broaden their research and "need theoretical frameworks that can guide our practice with communities in the face of such serious public health challenges" (p.2). With this in mind Stevens and Hall are positive that the use of critical theories "offer a process that can empower... nurses and empower the communities [they] serve to gain more control over threatening conditions" (p.3). Nurses who work in the community have a broad community profile and are in an excellent position to observe the inequalities that exist. By using a critical approach, nurses may, in turn, be able to empower themselves while working alongside community people. Together they may become aware of their oppressed situation and make appropriate changes.

3.4   Differences Between Critical Theory & Critical Social Science

Much has been written on both critical theory and critical social science. Fay (1987) has suggested there may be some confusion and I would agree. I have therefore included my interpretation and understanding of both, to assist the reader to develop their own understanding of critical theory and critical social science.

3.4.1 Critical Theory

Critical theory is based on a theoretical framework which is a philosophy with an interest in human life. Critical theory is connected to and developed from the Frankfurt School through the writings of Horkheimer, Marcuse, Adorno, and Habermas, cited in Held (1980). It was at this school that a number of German social theorists in the 1920's researched and put forward theories based on Marxism relating to advanced capitalism (Held 1980). The emphasis of critical theory is based on the values of freedom and democracy, which can be impeded by social structures, power, and oppression of the people. Fay (1987) explains that critical theory has another meaning, in that it is also a metatheory of social science. Fay expands on these initial theories and indicates that critical theory has two meanings. It is a theory of society, and a metatheory, that is a theory of itself. The aim of a social theory is to define its own underlying structures. Fay implies that although, in his view, these two theories are connected they are also made up of different elements.

It is for this reason Fay (1987) puts forward the argument that critical social science should be used as a metatheoretical analysis of social science and not the term "critical theory.". Fay's position is that a social framework is a science that has gone through a rigorous scientific approach to ensure that it has been objectively tested. We will come back to this position later in this chapter.

3.4.2 Critical Social Science

Critical social science evolved to accommodate a number of different critical theories developed by critical theorists (Roberts 1983; Allen 1985; Habermas 1987; Fay 1987) with

the intention that this might have practical political impact by informing government policy in an intellectual way (Fay 1987). It is therefore evident critical social science is not guided by a unified framework. It is, however, made up of a variety of perspectives offered by a number of theorists who each place their own understanding, meaning, interpretation and application to the science. What unites these theorists is their historical background including resistance against social conditions such as "fascism, colonisation, racism, exploitation of women, and prejudice against lesbians and gays" (Stevens & Hall 1992 p.3). They collectively believe people are oppressed and exist in a false consciousness because of the social factors and political conditions in which they live. Power is the unifying construct. They agree that humans can be freed from this oppression by raising their consciousness through education (critiquing false consciousness) which may assist in new understandings (enlightenment) and transformative action (emancipation). The aim of critical social science, therefore, is to emancipate people through collaborative facilitation from their taken for granted ways of being in the world. This may be achieved through consciousness raising, education and practical action (Fay 1987).

> *Critical social science is an attempt to understand, in a naturally responsible manner, the oppressive features of society and that this understanding stimulates its audience to transform their society and thereby liberate themselves.*

(Fay 1987 p.4)

Critical social science aims to provide a guide for people to understand their social world and make sense of their frustration, confusion and oppression (Carr & Kemmis 1997; Cody 1998). Critical social science is a living science of everyday struggles which are grounded in the historical context of a group's situation (Criab 1992; Stevens & Hall 1992). It is not idealistic theory of social life. It is both critical and practical at the same time. It is the practical side of critical social science which differentiates it from a simple theory. Critical

social science can only work directly with the people at the time of a crisis situation or when there is some sort of choice which has been forced on people. This situation places people in a social context in which they can no longer function as they did previously. Fay (1987) indicates it is at this time people are most responsive to the assistance of critical social science. There is always a crisis (or breakdown in the system) which leads people to look critically at their situation because they know they are unable to continue in the same way (Fay 1987). If changes in behaviour are inevitable then people can be assured that the circumstances which replace their current situation cannot be worse than what they were previously experiencing. This is because it is the people who are in control of their own destiny. This is what makes critical social science so sensitive to the individual circumstances of people's social situation. The people involved can only implement critical social science. This includes the circumstances that brought them to a current crisis or state of affairs and it names the people for whom it is directed, analyses their suffering and offers enlightenment about their potential needs. Critical social science points out to people in what way their ideas of themselves could be false and how the dominant group has shaped them. It also informs people about the particular social conditions that are oppressive and applies this in the light of how they can change their circumstances. Critical social science is an engaged science, relying on the participant's involvement to act on their newfound knowledge (enlightenment) while working in partnership with the researcher and/or theoretician. It is a science that applies its knowledge with a practical approach in the real world (Fay 1987). How the practical intent of critical social science takes place is to assist people to express their frustrations, grievances and resistance to the status quo. The science must always be adaptable to each and every individual situation, it is then that critical social science may guide the people involved.

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3.5   Perceptions of Reality

An underlying position of critical social science is that a dominant group which can override or influence the beliefs of oppressed groups may distort people's interpretation of their world. Only when their situation is exposed, will their consciousness be raised. Habermas, cited in Carr and Kemmis (1997), argues that people accept their life situations as real. Their powerlessness arises in that they don't realise life could be different and they do have the power to change their lives. Critical scientists help to distinguish between appearance and reality. What appears to be, is not always the case. Appearance can be based on illusion. These illusions create false consciousness and prevent people from realising their full potential (Fay 1975). Critical social science can help by illuminating the structures that support and promote this false consciousness. Critical social science aims to critique these myths and illusions and to expose peoples' taken for granted assumptions in a new light. These assumptions sustain a certain way of life, and are usually dearly held. People can became resistant to new understandings even when their false consciousness is raised (Fay 1975). Critical scientists, therefore, need to be aware of people's resistance to change (Wicks 1999). It usually takes a crisis to get people to question these taken for granted assumptions. For this to be effective people need to be in a position to understand and explain why the conditions in which they find themselves are oppressive, frustrating or confusing. For this reason critical social science is grounded in the socio-political context in which people live or work, and acknowledges that beliefs, tradition, cultural values, habits and language structure people's lives (Fay 1987).

3.5.1 Hegemony

Critical scientists see oppression as created not by nature but by powerful people who manipulate others so that they perceive and interpret things the way these powerful people want them to be interpreted (hegemony). Hegemony comes about through the development and acceptance of ideas by a powerful group (usually people in ruling positions). Power can be thought of as authority and coercion. Power is not an isolated factor, it depends on the willingness of the followers. The followers consent and accept the leader. The basic social construction of most societies means the decisions and actions are taken by the powerful. In this way people are led into false consciousness. Reality is, therefore, not a state of order but confusion, tension and contradiction (Bocock 1986). Through the process of distorted communication people accept and contribute to their own oppression (Wicks 1999). Hegemony explores how power is defined and maintained by social institutions to serve the interests of dominant groups (Bocock 1986). Dominant groups can influence people to support their way of thinking which then becomes the norm. This allows the dominant group's values and interests to continue (Wicks 1999) which can be referred to as the regime of truth. Regime of truth can be described as a set way of undertaking something or a certain expected behaviour which is not thought about or challenged.

3.5.2 Counter Hegemony

Counter hegemony, also known as ideology critique, brings to the surface the interests of the powerful which are maintained by the powerless who accept or conform to the status quo (Fay 1975). It is when the powerless or the oppressed become uncomfortable or a crisis develops that the people concerned may start to question or critique the status quo (the norm). They may then challenge their traditional opinions and assumptions which they

have taken for granted, which may assist them to see things in a different light (critiquing of false consciousness). This new found understanding or knowledge allows people, if they are willing, to liberate themselves (enlightenment) and gain a different perspective on their social situation. It transforms them through understanding, planning and action (emancipation). The aim is to learn how to empower oneself, not to manipulate the system but to alter the system. Liberation occurs through discussion. It involved reflection on the situation as preparation for demystification and the questioning of social situations. As people became responsive to their situation and new knowledge, assistance from a critical social scientist to guide them in their journey is recommended (Fay 1987).

3.6   Fay's Critical Framework

> *A critical theory wants to explain social order so that it becomes, itself, the catalyst which leads to the transformation of the social order.*
>
> (Fay 1987 p.27)

Fay puts forward the notion that there are a number of elements to a critical social science framework. First, there is a crisis in a social system; second, the crisis is due (at least some part of it) to false consciousness on the part of the participants; third, the false consciousness can be lifted and enlightenment provided for the participants and fourth, enlightenment may lead to emancipation in which people find new understandings which they can put into action and alleviate their suffering. Fay (1987) implies that it is only when all these elements have occurred that a social science is truly critical.

False consciousness	People are unaware of the social implications which direct their life.
↓	In a crisis situation people cannot resist change and carry on in the old ways. Must make a choice that is forced on them.
Crisis	▼
↓	Critical social science gains a foothold because only in this kind of choice/demanding situation, will the people be primed for it.
Enlightenment	▼
	Of those experiencing crisis, critiquing false consciousness through education leads to enlightenment which leads to empowerment.
↓	▼
Emancipation	New found understanding radically alters social actions and alleviates suffering.

(Four stages of Fay's 1987 Critical Social Science Framework, *my interpretation*)

3.6.1 Fay's Critical Social Science Measurement Criteria

Fay puts forward a model that can act as a standard to measure the outcomes of a critical social science. He suggests this model can also compare whether other critical theories are in fact true theories of critical social science or deficient in some area. Fay describes four different stages or theories. These theories include first, a theory of false consciousness which consists of three sub theories relating to the demonstration of how people's understandings are false; how the people have acquired and maintain these understandings, while providing an alternative improved consciousness. Second, a theory of crisis with three sub theories, which describe the crisis and why the crisis has occurred from an historical context and within the current socio-political context. Third, a theory of education with two sub theories that provides what is necessary for enlightenment. Fourth, a theory of

transformative action which describes two sub theories and highlights the current areas which need to be altered and a plan put into action to allow for emancipation. Fay argues that these four theories are all needed for the science to be critical. This is what Fay calls "The Basic Scheme" (p. 21) of critical social science. By offering this framework to the people at the time that they most need it, a critical social science can effectively explain a social order and in so doing can empower the oppressed people and overthrow the status quo.

The ultimate aim of critical social science is to alleviate people's suffering (Fay 1987; Habermas cited in Criab 1992). The people concerned wish to override their situation and seek transformative action. For this to be effective the people need to have a new understanding of themselves which has been directed by their newfound knowledge. This new knowledge can assist them to organise themselves into an effective group with the power to alter their situation and alleviate their suffering. It is therefore necessary before applying a critical social science to understand the constructs which are derived from it. These include; consciousness raising, enlightenment and emancipation. Each of these elements exists in relation to each other (Henderson 1995).

3.6.2 *Consciousness Raising*

Consciousness raising is a process by which people come to see themselves and their social situation in new ways. This process comes about through education (Fay 1987). Consciousness raising involves the acknowledgment by the people that there are social and political constraints which oppress them. There is then, an opportunity for people in similar oppressive circumstances to discuss and take action to overcome the constraints. According

to Freire (1972) consciousness raising requires dialogue between the oppressed and those with a theoretical understanding of oppression. They may be then in a position to work together to uncover the oppressive circumstances which they find themselves in.

3.6.3 Enlightenment

Enlightenment is a process of self-reflection (Fay 1987); seeing oneself within one's own context in a different light, while interpreting a situation (context) in a new way. It is then possible to compare the new way in light of the old way.

3.6.4 Emancipation

Emancipation is a process of liberation (Fay 1987). This means a consciousness of becoming aware of self and/or the situation which forms part of the socio-political context. It is not only knowing which emancipates people but having the collective power which assists in moving people together in a positive direction for their survival (Fay 1987; Henderson 1995). Enlightenment allows people the ability to seek below the surface and uncover the beliefs and illusions (false consciousness) and expose other possibilities and present these as a newfound reality (emancipation).

Critical social science creates a medium that allows people to express themselves in a safe, non-threatening environment. Its aim is to guide people to recognise and overcome their oppression. This can be achieved by influencing the socio-political environment in a scientific, critical and practical way all at once.

Critical social science provides a framework for examining and critiquing socially unnecessary constraints on human freedom while judging the contextual effects of power, knowledge and belief. Such an approach, it is believed, actively seeks to free individuals by raising their consciousness and allowing them to question the prevailing norms. The critical social scientist needs to be aware of the individual circumstances of the people. Rejection by the people can still occur even if they have been shown that their situation is false and incoherent. As Fay (1987) explains

> *A critical theory is not a static doctrine, a fully completed set of laws which are simply applied to, or imported on concrete situations: rather it is corrected and reformulated as it continually confronts the practical man it seeks to enlighten.*
>
> (p. 109)

I believe there are power issues in general practice that influence teamwork as already mentioned. It was my intention, when planning the research design, to give voice to each of the participants. In so doing, I was attempting to understand the views of others in an effort to give light to any contradictions and oppressive features of the General Practice System in New Zealand. Raising the consciousness of people who may be oppressed, while making sense of the attributes which contribute to this oppression, could assist in understanding the reasons why practice nurses and general practitioners are dissatisfied with the General Practice System and don't always work together as a team. However, as Fay (1987) states

> *The claims of such a theory can only be validated partially in terms of the responses that the social actors themselves have to the theory. It is partially determined by whether those for whom it is written recognise it as a way out and act on its principles. It is an internal- and decisive- criticism of any critical theory if it is rejected by the people to whom it is addressed.*
>
> (p. 110)

3.7   Critical Social Science and this Research Methodology

Underpinning this research within a critical framework required the development of a collaborative and trusting relationship between the researcher and the participants. This research has been undertaken in partnership with the participants.

Participatory research generates understandings which can lead to knowledge of the research area from the "experiences, lives and self-understandings of the human beings engaged in the research" (Henderson 1995 p.61). It was acknowledged from the outset of this research that there could be a power imbalance between myself (the researcher) and the participants. I made the participants aware of this and as the emphasis of this research was to highlight power and the socio-political constructions which can oppress both practice nurses and general practitioners, I was particularly aware I did not wish my position as researcher to oppress the participants' voice. For this reason I explained I was coming to this research as a naïve researcher. I was aware that by participating in this research the raising of the participants' consciousness could occur within a number of phases. Through dialogue at the planned focus group meetings and at the time of validation of the research data. In addition within the participants' own clinical practice area, that of the General Practice environment.

3.8   Conclusion of Chapter

I took into consideration Fay's (1987) contention that there are four main theoretical areas to consider in critical social science when analysing and interpreting data. First, critical social science offers a medium which provides an awareness of the self-understanding of a

group of people which could be false or incoherent. Second, usually it takes a crisis to get people to question their taken for granted assumptions and for a critical theory to be effective. A crisis which oppresses the people needs to be acknowledged by those affected. The crisis requires an examination of the people's dissatisfaction and the way it threatens the social cohesion of society. Third, a critical social science acknowledges that the availability of appropriate education may assist people to develop a deeper understanding of their circumstances and social situation. The fourth theoretical area, transformative action details a plan of action for change, which may ultimately lead to the emancipation of people. Dialogue from the focus groups provided this forum. How this was achieved will be described in the next chapter highlighting the research aim, design and implementation.

CHAPTER 4
Research Aim, Design & Implementation

4.1 Overview of Chapter

This chapter will discuss the development of the research idea which was conceived as a first step to assist individuals from core primary health care teams to work collaboratively whilst making the best use of their individual expertise. The chapter will then describe the research aims whilst taking into consideration the research question, study design, implementation and trustworthiness.

4.2 The Development of the Research

It was my intention to research one identified barrier to teamwork, that of the perceived confusion about interdisciplinary roles. This confusion may result in poor understanding of the value of the contributions provided by each member of the team. I decided to study the understanding of role in greater depth. Role perception has become the central focus of this research.

4.2.1 The Aim of the Research

The aim of this research was to gain a clearer understanding of practice nurses' and general practitioners' perceptions of each other's roles in the belief that this process would assist in improving teamwork for the practitioners in the General Practice setting.

4.2.2 *The Research Questions*

The research aim was addressed through three main themes. The first theme set out to explore practice nurses' and general practitioners' understanding of their own roles. Second, to explore practice nurses' and general practitioners' understanding of each other's roles. Third, to enable practice nurses and general practitioners to gain new understandings of each other's roles within an expanded primary health care service in general practice.

4.3   Research Design

The aim of this research had a profound influence on my decision to use a qualitative approach to generate data. Qualitative research is used to understand people's individual experiences. This approach allows for a clearer and more open understanding of the research topic while taking into consideration the context in which the participants live or work (Guba & Lincoln 1994; Mays & Pope 1995; Crotty 1996). When qualitative research is applied to the social context it offers a deeper analysis of that experience. My intention was to invite comment from the participants (practice nurses and general practitioners) of their own and each other's roles in the General Practice setting. I hoped this would support the idea that the lack of understanding of role was indeed a barrier to teamwork. My assumption was that there could be elements of the practice nurses' and general practitioners' roles about which the other group was not aware, or about which they lacked understanding. I wished to explore both the overt and the covert factors which influenced the participants' understanding of their practice and beliefs of role.

A variety of qualitative research approaches could have been used to acquire this information. These include; ethnography, phenomenology, open-ended interviews and case

studies (Patton 1994). As a qualitative researcher I was attempting to understand the views or positions of the participants being studied. I was trying to understand what they were experiencing (Guba & Lincoln 1994; Mays & Pope 1995). If new insights of the participants' roles did develop through the research then it would be advantageous for the participants to hear and take part together in the discussions. It was for this reason I chose to use focus groups as the method of generating data, rather than any of the other approaches as mentioned. It was my intention to use focus groups to generate open discussion on the topic, to stimulate reflection and discussion and to develop a greater understanding of the individual and collective roles of the participants.

In addition this research was guided by critical social science. Critical social science works on the assumption that through dialogue the contradictions between words and actions will be exposed. By using focus groups to generate discussion, critical social science has assisted in the analyses of the data by highlighting the participants consistencies and contradictions identified as resistance, false consciousness and hegemony in the dialogue. It was hoped by using this approach it would provide the participants a medium for raising consciousness while assisting them to work together to address the inequalities of their practice (Manias & Street 2000).

4.4   Research Method - Focus Groups

4.4.1   Background to Focus Groups

Focus group meetings have been discussed extensively in the literature (Morgan 1988; Krueger 1994; Kitzenger 1995). Focus group meetings were first used as a market research

technique in the 1920's (Kitzenger 1995). In the 1930's they were used by social scientists (Krueger 1988), who discovered the advantages of focus group meetings for generating information. This was because the participants of focus groups were encouraged to explain and share their attitudes through open-ended questions. This approach of gathering information was in contrast to the traditional closed ended questioning found in more traditional methods such as structured questionnaires. It was at this time the emphasis moved from the researcher to the participants' views and their position on a topic (Kruegar 1988).

4.4.2 Appropriate Use of Focus Groups

Focus groups can be used in a variety of situations, for example, in the planning and the evaluation of new programmes to produce ideas for developing marketing strategies, in formatting content and/or for pre-testing questionnaires (Morgan, 1988). Nursing research, has previously used focus groups to explore a number of areas in nursing education (MacIntosh, 1993; Luker, Carlisle & Kirk 1993; Lankshear, 1993). Recently nurses have used focus groups for their research to address the inequalities of power issues (Manias & Street 2000). In the General Practice setting focus groups have not been used extensively as a method of research (Bannon, Carter & Ross 1999).

Focus groups have been used to examine people's understandings of cultural issues, work place cultures and the way staff have coped with the terminal illness of patients (Nyamathi & Shuler 1990; Kitzenger 1995). Focus groups have been appropriately used when the researcher requires information on delicate or sensitive subjects (Morgan 1988; Krueger 1994; Kitzenger 1995) or when the issues are unclear or have poorly defined subject areas.

Krueger states that:

> *evidence from focus group interviews suggest that people do influence each other with their comments, and, in the course of their discussion, the opinion of an individual might shift.*

<div align="right">(1988 p. 23)</div>

This raising of awareness is consistent with the theoretical basis of this research, which is informed by critical social science.

The use of focus group meetings allows in-depth exploration and description of the participants' views on a specific topic. As expressed so eloquently by Des Rosier and Zeller (1989) a focus group meeting provides:

> *A specific communication process, whereby a different breadth and depth of interaction, spontaneity, and cross-fertilisation can occur, allowing participants to pick up ideas from one another.*

<div align="right">(p. 21)</div>

This suggests that the importance of *interaction* is a key element in generating discussion on the focused topic amongst the participants of the focus group. Morgan (1988) reiterates the importance of *interaction* when he states:

> *The hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group.*

<div align="right">(p.12)</div>

Throughout the focus group discussion the participants interact and in so doing their opinions may change (the fundamental aim of critical social science). However, it is important to take into consideration that focus group meetings are not set in a natural social setting. This artificial setting can lead to a number of disadvantages in generating interaction between the focus group participants. Krueger (1988) has identified two main

disadvantages of holding a discussion in a *non-natural* setting. First, discussion may be difficult and awkward, especially if the topic is a sensitive one. There may be a misrepresentation of what the participant is saying in relation to their actual attitudes or thoughts. Krueger (1988) argues that people tend to be selective about what they disclose about themselves, especially in a non-natural setting. Second, it takes time for participants of a focus group to build up trust in one another and to become accustomed to holding a discussion in a non-natural setting.

4.4.3 Participation in Focus Groups

Focus groups are generally composed of people who possess similar characteristics (Kingry, Tiedje & Friedman 1990; Krueger 1994). In other words they need to be relatively homogenous, with the purpose of the study determining the nature and extent of their homogeneity. As the aim of this research was to generate discussion amongst practice nurses and general practitioners, the initial plan was to have all participants together at each focus group meeting. However, on further consideration, this was discarded in favour of establishing one group of practice nurses and the other of general practitioners. These two groups were later combined into one. The reason for initially establishing two homogenous groups was to ensure all participants a relatively safe environment within their own peer groups which should allow for more open discussion. Opinions and experiences could be shared separately by the different disciplines before coming together into a situation with potential power imbalances.

Krueger (1994) states it is desirable for the participants of focus groups to be complete strangers. The reason given for this is because participants who know of each other may be

consciously or sub-consciously influenced by past experiences, each other's opinions and style of communication. This could affect the relationship and inhibit the free flow of the participants' discussion. However, in some areas, it is virtually impossible to ensure all participants are strangers. Nevertheless, close friends or those who either work together or who are in regular social contact with each other, present special difficulties for focus group meetings, as indicated above. A related yet equally important issue, is the familiarity between the facilitator and the participants. Familiarity could lead to difficulty in isolating what influenced the participants' views when analysing the data. The reason behind this relates to participants who had built up a relationship either professional or personal prior to attending the focus group meeting. Such participants' responses may be influenced by past or present interaction, which could alter the dynamics of the remaining focus group participants and discussion (Krueger 1994).

Morgan (1988) and Krueger (1988) have discussed the advantages and disadvantages of having both large and small participant membership at focus group meetings. Ideally the size of the focus group should be small enough for each participant to have the opportunity to share insights and yet be large enough to provide diversity of perceptions and opinions. Morgan (1988) and Krueger (1988) argue the number of participants in a group should be between six and eight. The minimum number of participants for a focus group is four and the maximum is twelve. Clearly, with a larger number of participants in a group it will be more difficult to facilitate. A large group of participants tends to break up the discussion into smaller group discussions with people talking amongst themselves. This leads to fragmentation of the group and can result in tape recording difficulties and deviation from the main topic question. In addition, in larger groups it is difficult for all participants to

share their views on the topic. Large groups generally need a higher level of facilitator involvement. Smaller groups, on the other hand, may require more individual input from the participants. I took this information into consideration in the design of my focus group meetings.

4.5   The Focus Group Meetings

4.5.1   The Focus Group Design

Six focus groups in total were planned for this research. There would be initially two groups, one of practice nurses and the other of general practitioners. Each group would have two individual focus group sessions. These two groups would then be combined into one bigger group for the final two focus group sessions.

The focus group meetings would commence in March 1999 and were to be completed by July 1999. The six focus groups were divided into four phases. This is represented figuratively by Figure 1, on page 82. This figure displays the sequence of the six focus group meetings. The diagram has been divised into four phases which include the individual practice nurses' (1A & 2A) and general practitioners' (1B & 2B) groups, the two combined practice nurse and general practitioner groups (3 & 4) and the focused questions associated with each of the phases.

Phase	Practice Nurse (PN) A	General Practitioner (GP) B	Focused Question

Phase I — 1A — *themes* — 1B — *What are the roles/tasks of a practice nurse? (A) or general practitioner? (B)*

Phase II — 2A — *themes* — 2B — *What are the roles/tasks of the other discipline?*

Phase III — 3 — PN | GP — *Do you understand each other's role?*

What are the concerns about funding for general practice services?

Phase IV — 4 — PN | GP — *Is there a difference between role & function?*
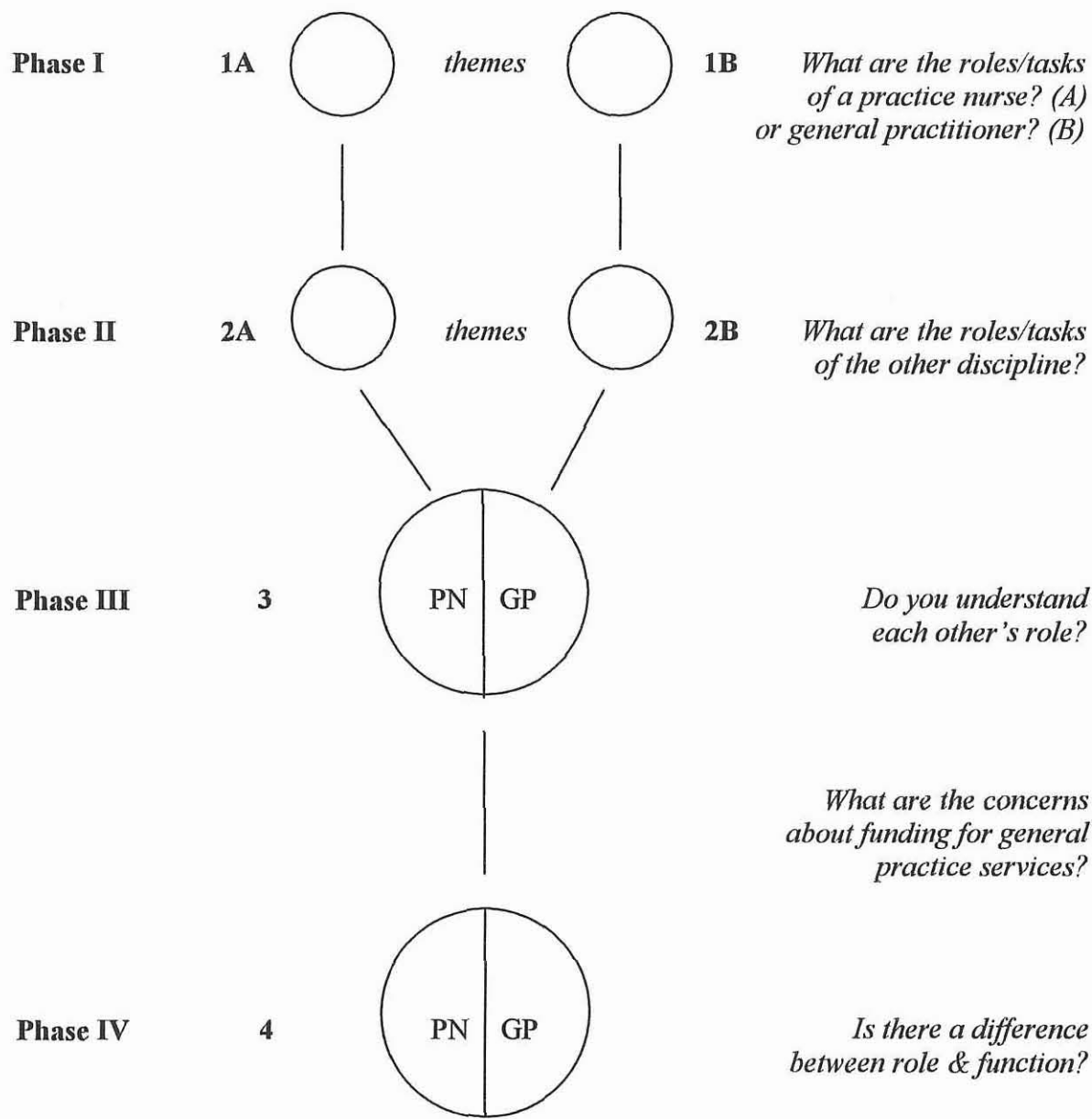
Focus Group Design (Fig. 1)

4.5.2 Facilitating a Focus Group Meeting

Focus group meetings are not easy to facilitate (Krueger 1988). The main task of the facilitator is to allow participants to share their own views and opinions in an open forum and to ensure each participant has an equal opportunity to contribute. The facilitator should be prepared for the meeting with the main topic question clarified and a number of sub-questions to be used if required (Murphy, Cockburn & Murphy 1992; Jackson 1998). My role as facilitator was pivotal to the quality of the data collection. I gave the discussion a direction, encouraged participation and probed the participants to contribute further to the discussion (Hisrich & Peters cited in Nymathi & Shuler 1990). I played, as DesRosier and Zeller (1989) state, the interested party.

I explained to the participants at the onset of the research that I was a nurse who had recently worked in rural general practice, and that I was particularly interested in what I could learn from them by guiding the discussions around the topic, rather than leading the conversation.

It was essential I felt comfortable with the facilitation process and that I was clear with my directions as to what I wished the participants to do. I was aware that the requirements of a facilitator were not only to be in tune with the purpose of the research, but also to have the necessary skills to guide and adapt to the mood of the group (DeRosier & Zeller 1989). As a facilitator I needed to focus the discussion on the areas of concern and avoid conflict, while providing a safe space for the participants to discuss the topic/s.

To prepare myself for the facilitation role, I attended a weekend course on facilitation skills at Canterbury University, Christchurch, New Zealand. This course assisted me to grasp the complexities of skillful facilitation and the level of questioning necessary for the planning, coordination and smooth running required for focus group meetings. A well-planned meeting allows the facilitator and a participant to relax and enjoy the meeting process and reduces anxieties. The benefits of this can assist in a more productive session for all the participants (Krueger 1988). I decided to invite an assistant to help with the focus group meetings as recommended by Krueger (1988).

4.5.3   Focus Group Assistant's Responsibilities

The assistant's responsibilities' were to set up the focus group venue in preparation for the focus group meetings, by ensuring the tape recorder and the microphone were in working order. The assistant was an experienced transcriber. She had exceptional knowledge on how meeting rooms should be set up appropriately for tape recorded discussion. She also helped by presenting, offering and clearing up the light supper and refreshments. I found her help at the focus group meetings invaluable for the success of the focus group data collection as it freed me up to concentrate on group dynamics and to keep the discussion going. The assistant signed an agreement of confidentiality to partake in this research (Appendix 1).

4.6   Ethical Considerations Relating to this Research

I was particularly aware that this research could have a number of potential effects on the participants. These potential effects included the possible dominance by some members of the focus group. These could include the quiet/shy participants requesting answers from the

discussion rather than contributing. The raising of sensitive issues and the potential for participants to disagree or argue with each other could lead the discussion away from the topic. In particular, the Ethics Committee was concerned about the potential for gender differences which could raise grievances and power imbalances between the general practitioner/nurse and employer/employee relationships.

The Canterbury Ethics Committee granted ethical approval in November 1998 when the proposal was provisionally approved (see Appendix 2). There were a few minor alterations required by the committee prior to them granting full approval which was given in December 1998 (Appendix 3).

The main alteration required by the Canterbury Ethical Committee was that the third theme of the research should clearly state, to *"enable"* practice nurses and general practitioners to gain a new understanding of each others' roles. Clarification was required with regard to how I would account for the participants working in the same general practice or from other practices and how would individual participants be protected if there was more than one participant from the same general practice contributing to the research? Clarification was also requested on what information from the focus group discussion would be available to the participants for editing.

The above areas were reworked to include "enable" for the first alteration and participants from the same or different practices would be invited to provide their profession and work location on the reply slip when they indicated their interest in participating in the research. If by chance two or more participants from the same General Practice volunteered to

participate in the research, the researcher would select only one participant. The themes drawn out from the transcripts would be sent to the participants for their validation only and not for them to edit their own comments.

4.7   Implementation of the Research Design

4.7.1   Recruitment of Potential Participants

Following Ethics Committee approval (Appendix 4) for the study to go ahead, letters of invitation (Appendix 5) were sent out using a sample of convenience. The address list was obtained from the Continuing Education Unit of the Department of General Practice where I work.   Letters were sent to eighty practice nurses and general practitioners within the urban and rural areas of the Canterbury region of New Zealand. The letters of invitation briefly described the purpose of the research aim, the research process, the involvement required of participants and the ethical considerations. Interested respondents were invited to post a reply slip back to me, indicating their interest in participating.

Positive responses were received from four practice nurses and three general practitioners. However, I was aiming for a minimum of eight participants and a maximum of twelve for the focus groups to be viable. Between four and six practice nurses and a similar number of general practitioners was required. I was mindful of Krueger's (1994) advice that it is necessary to over recruit the number of participants if possible, to avoid non-attendance at future focus group meetings.

At this stage I still needed to recruit at least two more participants; a practice nurse and a general practitioner. A further twenty letters were sent out; ten to practice nurses and ten to general practitioners.

I also attended two continuing professional education evening seminars held for practice nurses and general practitioners in the Department of Public Health and General Practice, Christchurch School of Medicine. At these meetings I explained the purpose of the research and the level of involvement required. I invited the attendees to consider enrolling. These two events provided a further two practice nurses. The final general practitioner was recruited on the suggestion of my supervisor.

On receipt of the expression of interest, each participant was contacted by telephone to arrange an individual meeting. I visited four potential participants at their place of work. The remaining participants were contacted by telephone only instead of visiting which was more for convenience for the participant and myself because of limited time. The meeting provided a fuller explanation of the purpose of the study and written details of the research design were given for consideration (Appendix 6). The participants were invited to read the focus group's core ground rules (Appendix 7) and sign the research consent (Appendix 8). I also discussed individual participant concerns about participating in the research prior to seeking written consent

Arranging times for practice nurses and general practitioners to meet conveniently together for six consecutive one and a half-hour meeting was much more difficult than I had expected. This was because of the time commitment required of the participants to

participate in the research. I had provisionally planned the date, time slots and the venue for six focus group meetings commencing in March and ending in July 1999. This was for the convenience of the participants to see if they could agree to participate once they knew of the time commitments involved.

Although six focus groups were planned, each participant was only required to attend four focus groups in total (refer back to Fig.1 p.82). After much deliberation six practice nurses and four general practitioners from a total number of eighteen interested potential participants consented to participate in the research. They all worked in the Canterbury region of New Zealand.

4.7.2 Demographic Details of Participants

Demographic details of the participants were obtained from each of the participants by inviting them to complete a form of their demographic details (Appendix 9). One group comprised six female practice nurses from both urban and rural regions of Canterbury New Zealand. Their experience of practice nursing ranged from two to seventeen years.

Five of the nurses were from urban general practice and one from a rural area. The practices in which they worked were aligned to two separate Independent Practitioner Associations (IPA's), both of which are funded in the traditional GMS fee for service based funding system. Four urban participants were part of a local IPA, namely the Pegasus Practice Group, with one urban participant working within a capitated GMS funded practice. The rural participant was part of a large IPA in the South Island and was funded on a GMS system.

The second group comprised four general practitioners, three females and one male. Three were from urban general practices and one from a rural practice. All but one general practitioner was from a GMS fee for service funded practice. The remaining participant was from an urban capitated GMS funded practice. Their experience of general practice ranged from six months to twenty years.

I was aware that, in an ideal world, focus groups should not comprise participants who knew each other or work together (Morgan 1988; Krueger 1994). It was always going to be likely that the participants who made up the membership of the focus groups were known to each other and could possibly work together. This was because of the size of the location chosen for this study (Canterbury, New Zealand) and the specific area related to health care; that of general practice. The Ethics Committee was also aware these issues may arise and they were interested to know how I would handle the situation if one or more participants worked together.

I had stated to the Ethics Committee that I would select only one of the participants concerned. This would minimise personal and/or professional issues from arising. It did, however, raise a problem for this research as two of the participants worked in the same general practice, one a general practitioner and the other a practice nurse. I discussed with each of them individually the implication of employer/employee; doctor/nurse relationships (Reed & Roskell Payton 1997). I explained to the participants that if both of them attended the focus groups this could potentially influence their ongoing relationship. Despite this warning, both participants continued to want to be part of the research study.

I discussed the situation with my supervisors and took the opportunity to discuss this further with the staff at the research school held at the Department of Nursing and Midwifery, Victoria University in Wellington, New Zealand. The nurse lecturers and fellow research students advised me that it would be inappropriate to have a practice nurse and the general practitioner who worked together present at the same focus group meeting. This was because of the particular relationships involved as previously described. I further raised this with the participants concerned who were both still very keen to continue with the research. I felt it would be satisfactory if they both attended the individual discipline specific focus group meetings which were held separately and for just one of them to continue on to participate in the joint practice nurse and general practitioner focus group meetings.

This was acceptable to both my supervisors. I invited the general practitioner (because I had a limited number of general practitioner participants) to continue to participate at all of the focus group meetings. I asked the practice nurse to contribute in person only to the first two focus groups and to the remaining focus group discussions in writing. This suggestion was satisfactory to both the participants.

4.8   Focus Group Meetings - Setting the Scene

4.8.1   The Number of Focus Groups

Six focus group meetings were conducted between March and July 1999, each of approximately one and half-hours duration and at times convenient for the participants.

The six focus groups were divided into four phases (see Fig. 1) and consisted of the same participants, but a different number of participants per focus group. Although all of the participants were invited to attend the focus group meetings, because of their other commitments it was difficult for all participants to be at each focus group meeting. The practice nurses and general practitioners each met separately on two occasions. The group size varied between four and six participants. The combined practice nurse and general practitioner focus groups met twice and contained between three and nine participants.

4.8.2   The Focus Group Format

The venue for the focus group meetings was a convenient place for the participants, in the centre of Christchurch, New Zealand. I tried to provide a relaxed, comfortable, warm environment in which to hold the focus group meetings (Krueger 1994). The seating arrangements comprised of chairs placed in a circle to encourage all participants to see and talk to one another with ease (Kitzenger 1995). Refreshments, light supper and non-alcoholic beverages were provided at the beginning and end of each meeting. I provided individual name badges, including first names, which I placed on each participant's chair. The intention of using name badges was to assist the participants to get to know each other, by addressing each other using first names. Addressing each other by first names made it easier for the research assistant to identify each participant whilst taking field notes and later in the process of transcription. At the first focus group meeting the name badges were randomly placed on the chairs. However, in subsequent focus group meetings, I particularly placed the name badges according to how participants contributed verbally at the previous focus group meeting. For example, if a participant was talkative and contributed extremely well, I placed the name badge inviting the participant to sit next to me. Alternatively if a

participant had been particularly quiet, I placed the name badge inviting the participant to sit opposite me (Kruegar 1994). The placing of participants according to the above criteria made a difference in how the participants contributed at subsequent focus group meetings.

At the commencement of each of the focus group meetings the participants were invited to introduce themselves, explain where they worked and how long they had been working in general practice. They were also reminded of the confidentiality of the discussions and that all material that was generated from the focus group meeting would be securely stored. This material (raw data) would only be available to the assistant, my supervisors and myself. The quotes used from the focus group meetings would appear in the themed transcripts after being coded. All evidence, which could link particular participants to a quote, or annotations from the themed transcripts, would be removed and coded using random letters of the alphabet. All quotations were further coded to highlight whether it belonged to either a practice nurse or general practitioner.

The coding of the participants' quotes and the protection of the full transcripts was undertaken to protect the participants, not only to respect their contribution but also to allow them the freedom to speak. Each participant had been informed both verbally and in writing about the purpose of the study, procedure, ethical considerations and the participant's rights in participating in the research. Subsequently at each meeting the participants were reminded of the importance of adhering to the agreed core written ground rules and were invited to add additional ones. No additional ground rules were suggested by any of the participants at any of the focus group meetings.

At the completion of each focus group meeting the participants were thanked for attending and contributing to the discussion. They were told they would receive the themed transcript for their validation well in advance of the next focus group meeting. I also reminded the participants of the date of the next focus group meeting. At the commencement of subsequent focus group meetings the participants were invited to comment on the themes and quotes identified in the transcripts from the previous focus group meeting.

In addition the participants were reminded that if they had a personal or professional issue which arose from the focus group meeting then they might like to consider making contact with me to arrange further professional assistance if necessary. Participants were free to withdraw from the study at any stage. It was made clear that if they did withdraw (which did not occur) it would have no effect on the participant's future relationship with the Department of Public Health and General Practice in Christchurch.

Following the departure of the participants, at every focus group meeting the assistant and I discussed the meeting, noting down important aspects. This helped in the difficult circumstances of muffled tape recordings, due to a dying battery in the microphone, which occurred in the very first focus group meeting (1A). It also avoided incomplete participant sentences, which assisted in the understanding of the discussion and ultimately the validity of the research. This was because the assistant took written notes of the discussion as well. I would certainly agree with Sim (1998), who implies that the collection of focus group data can be difficult. I wrote up field notes of the meeting which, on reflection, assisted in contributing to the data collection. I also debriefed within a week or two following the

focus group meeting with my supervisors. The debriefing included a review of the conversation, all the data and how I was going to proceed with the analysis of the data.

4.9   Focus Group Data

The key to a successful focus group data collection, with the aim of generating a productive discussion, is a focused topic which can be discussed openly in a well facilitated, supportive, non-judgmental environment (Morgan 1988; Krueger 1988). Having a topic to discuss at a focus group meeting focuses the thoughts of the participants which can then tap into the attitudes and perceptions relating to the topic under discussion (Krueger 1988). When simple questions in normal social situations are discussed a person could answer in a couple of minutes. However, when a similar question is asked at a focus group meeting the answer may take longer. This is because focus groups invite participants to divulge and discuss together their views, which does not usually occur with other forms of questioning (Krueger 1994). My role as the facilitator was to keep the participants focused on the topic questions, probe deeper into the topic and encourage conversation, ensuring all participants had an equal opportunity to contribute (Murphy, Cockburn & Murphy 1992).

4.9.1   Topics for Discussion at Focus Group Meetings

I put to the group a series of open-ended questions relating to the objectives of the research; that of the participants' perceptions and understanding of their own and each other's tasks and roles (refer back to Fig. 1). The participants generated further questions which were then discussed by the group. General themes occurred throughout which provided insight into the motives for participants' beliefs and opinions on the topic. (refer to Chapter 5).

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4.9.2 Collection of Focus Group Data

The meetings were audio taped recorded and subsequently transcribed. A number of themes were drawn from the transcripts. There were a number of other ways I used to collect the data. First, I explained to the participants that I felt the ideal way of understanding the diversity of their role both for myself and for the participants was to use the "sticky paper" method. This method required the participants to write each component they considered being the role or task of the practice nurse and/or a general practitioner on individual pieces of sticky paper. These pieces of paper were then placed onto flipcharts provided on the wall. This was a convenient way to categorise the participants' skills and roles in a relatively short time frame. The categories were then written on the electronic whiteboard and further discussed, themed and validated by the group.

4.9.3 Analysis of Focus Group Data

Stewart & Shamdasani, (1990) note that in some quarters there is a great deal of skepticism about the value of focus group data, mainly concerned with the quality of analysis, the subjective nature of the interpretation depth and understanding of the data. However, from their experience "the analysis and interpretation can be as rigorous as other methods" (p.103). It is therefore necessary to apply a great deal of judgment and care when gathering, analysing and interpreting data. When documenting the process of this study it was important to identify all the steps of the research clearly to provide an audit trail (Lincoln & Guba 1985) so the reader could track data from each focus group meeting.

A "cut and paste technique" required me to read through the transcripts then to cut and paste the relevant quotes (Krueger 1994). This assisted in generating the themes and helped

make sense of the discussion. The themes become an important link to the discussions by using the most useful quotes to highlight why the themes were chosen.

The themes and relevant quotes pertaining to the focus group transcripts were sent, prior to a subsequent focus group meeting, to the relevant participants of that focus group for their validation. This also acted as a prompt and educative process which assisted in focusing the participants' discussion at the subsequent focus group meetings. In addition, this process contributed to the trustworthiness of the dialogue by the participants.

4.10   Trustworthiness of the Research Data

The trustworthiness relates not only to the results of the study, but how the process of the research was recorded, and the thinking which took place to create and proceed with the research. Nolon and Behi (1995) argue that the way a research study is legitimised depends on the "exploration of conditions, philosophical underpinnings and assumptions within the research work" (Koch & Harrington 1998 p. 335).

Analysis will be validated if the results are "believable" (Krueger 1994). To validate qualitative research according to Guba and Lincoln (1981) requires the following to be applied, credibility, transferability, dependability and conformability. Sandelowski (1986) brought these areas of validation to the attention of nurse researchers. Many nurse researchers have been influenced by Sandelowski (1986) and likewise Koch's (1994) work has influenced nurse researchers on the validation of qualitative research.

4.10.1 Credibility

Credibility can be enhanced when the interpretation of the data represents accurate descriptions and experiences that the participants could recognise as their own (Guba & Lincoln 1981).

To ensure the accuracy of the participant's discussions they were given four opportunities to review their discussions. The participants were invited to draw up categories of their roles, during the focus group discussions. At the completion of each focus group meeting the participants were invited to add additional comments. The themed transcripts were returned to the participants for their comment. This process contributed to the credibility of the dialogue by the participants. The analysis of the data formed a continual process throughout the research in parallel with the themes and dialogue generated at the focus group meetings. A descriptive account of all the themes, ideas and conclusions was used as a basis for the overall critical analysis of the information on the topic.

4.10.2 Transferability

The participants in the focus groups were volunteer practice nurses and general practitioners, who showed an interest in contributing to the research. Clearly the data arising from the focus group discussions alone cannot be assumed to apply to all core primary health care practitioners. The stated aim of this research was to explore the opinions of the participants rather than providing generalisable results. Sandelowski (1986) explains that the duplication of qualitative research results is inappropriate and that the uniqueness of the variety of results demonstrates the complexity of both human experience

and research. The journey the researcher takes to acquire the research data should be available and easy to follow for another researcher to duplicate the design.

4.10.3 Dependability and Confirmability

Examining both the research design and process attests to the dependability of the research. Once the findings, analysis and interpretation are supported by the data the conformability of the research is established. To ensure this is successful Lincoln and Guba (1985) suggest an audit or inquiry trail should be clearly written. An inquiry trail examines both the process and the development of data from the research. This assures the reader that the research is dependable by affirming that the research process supports the findings, analysis and interpretations it is then conformability can be established.

When documenting the process of this research, it was necessary to identify all the steps of the research clearly. This provides clarity for the reader of exactly the process that occurred. The research method and each focus group meeting have been described in depth, to assist in tracking the research process. Qualitative research acknowledges the data can never be completely free from the researcher's own position. Wherever possible, I have tried to acknowledge my own opinions and values in the description and interpretation of the research data. This contributes to the rigor of this research.

4.11   Conclusion of Chapter

Focus groups were chosen as the preferred medium for discussion on the research topic. Focus group discussions allowed the participants to express and share their opinions through conversation. A safe and conducive environment was necessary to aid a discussion which was open and honest which could take place to allow a trusting relationship to be built up between the participants. The focus group medium provided an opportunity for the participants of this research to contribute and discuss their understandings and perceptions. The focus group discussions by the participants were open and flexible, allowing intensive exploration of their opinions, feelings, attitudes and beliefs. The differences between participants can be further identified leading to arguments, and/or points of agreement, which are not possible through quantitative methods. A descriptive account of all themes, ideas and conclusions assisted the overall critical analysis of the information on the topic. The ensuing task was to prepare an interpretive account of what was discussed from each of the focus group meetings. The account was generated and supported by the transcriptions, paper data and field notes. The analysis and my interpretation of the data will be discussed in the following chapter.

CHAPTER 5
Analyses & Interpretation of Focus Group Meetings

5.1 Overview of Chapter

The aim of this chapter is to provide a description and analysis from a total of six focus group meetings. The data are arranged in a number of themes which follow the discussions that took place at the focus group meetings. Each focus group is described separately and includes a brief description of its membership, the initial question, the themes which emerged and my interpretation of subsequent discussions. My interpretation has been drawn together in light of Fay's (1987) critical theoretical framework. As I analysed the data I was particularly interested in the consistency, resistance, contradictions, false consciousness and enlightenment of the participants' individual and collective contributions of the discussions on the topic questions as discussed previously by Fay (1987). This approach has assisted in my understandings of the contextual effects of power and oppression which may be associated with the work carried out by practice nurses and general practitioners. My aim is to share with the reader my interpretation of the research data in light of the socio-political context of New Zealand's General Practice health system as discussed previously in Chapter 2. This may assist in a clearer understanding of how practice nurses and general practitioners have been shaped by the socio-political context in which they work.

Figure 1, described in Chapter 4, displays the sequence of the six focus group meetings which have been divided into four phases associated with the initial topic questions. These will now be discussed in turn.

5.2   Analysis of Data- The Focus Group Meetings

5.2.1   Phase 1

Question: *What are the roles/tasks of a practice nurse as perceived by the practice nurses and general practitioners?*

Phase 1 consisted of two individual focus groups, comprising of either a group of practice nurses or general practitioners, each group meeting separately. The practice nurse focus group will be referred as 1A, while the general practitioner focus group will be referred to as 2B. Figure 2 below is a replication of Figure 1, with the shaded areas identifying the focus groups associated with this phase.

Practice Nurse   General Practitioner

Phase 1 Focus Group Meeting (Fig. 2)
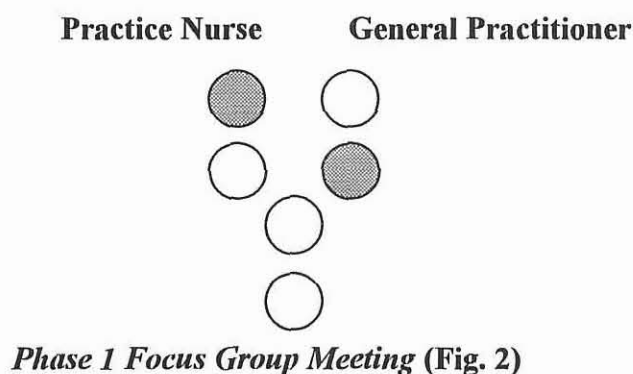
i)   *Focus Groups 1A & 2B*

The participants from focus group 1A met together for the first time whereas, the participants from 2B had met previously in focus group 1B (described later in this chapter). Focus group 1A comprised of six female practice nurses. Focus group 2B comprised four general practitioners, three females and one male. The participants of these focus groups where asked to identify independently their perception and understanding of the role and tasks of practice nurses for the provision of General Practice services in New Zealand. They achieved this by using the "sticky paper" method (refer back to Chapter 4). The "sticky paper" method was the first activity both these focus group participants undertook

before they discussed their thoughts on the topic. The method took approximately seven minutes, sufficient time for the participants to list their understandings' of the role. The lists are provided in tables 1a (p.103), 1b (p.104), 1c (p. 104). The first table (1a) comprises both the practice nurses' and general practitioners' shared indications of what they thought the components of the practice nurse role were. There are a number of items which the practice nurses only identified as their role and these are found in table 1b. A third list of what the general practitioners listed as the practice nurses' role but were not identified by the practice nurses are found in table 1c.

It is not too surprising that both practice nurses and general practitioners individual lists (tables 1b, and 1c) were similar. They resemble a summary of the role of a practice nurse. Inviting the participants to list the activities associated with the practice nurse role generated a large amount of data which assisted in focusing the participants on the components of this role. I have summarised the core role of a practice nurse as:

> *The core role of a practice nurse is concerned with patients' ongoing health care by providing health education, advocacy, effective communication and coordination.*

Likewise, I have summarised the core role of a practice nurse from the description offered by the general practitioners' as:

> *The core role of a practice nurse is to provide a variety of procedural services. These include; patient education, effective communication, coordination between patients and health professionals and administration of health centre and services.*

As can be seen, both summaries describe the varied role of a practice nurse. The role requires the practice nurse to use a number of skills to undertake a number of tasks. These included being an effective educator, a communicator and coordinator between a number of people in the complex health sector. However, in my view there appears to be a different emphasis placed on the two summaries. The summary generated from the practice nurse data is patient centered. Whereas the summary developed from the general practitioners' data, although it appears similar in content, is more directive, perhaps illustrating a power differential between the general practitioner and the practice nurse.

List of the components of the practice nurse's role identified by BOTH the PRACTICE NURSES & GENERAL PRACTITIONERS:
Administration
Assisting
Blood pressure
Blood testing
Coordinating nurse cover / management of
Cervical smear
Ear syringing
ECG
Home visits
Housekeeping / Equipment sterilisation
Immunisation & vaccination - travel, flu, childhood
Keeping systems up to date
Liaison patient/doctor, hospital professionals
Ordering stock
Rest home visit
Smooth running of the system – appointments, time management
Suturing
Triage patients
Wellness clinics

(Table 1a)

List of the components of the practice nurse's role identified by the PRACTICE NURSES ONLY:
Advice / advocate: communication, telephone
Answer telephone
Antenatal - pre doctor
Attending meetings
Audit
Computer documentation
Contraceptive advice
Diabetic management
Educator
Giving / writing up results
Health promotion
Liquid nitrogen
Listener
Lists: screening, health promotion, tasks
Medicals
Perusing results
Referral letters
Repeat prescriptions
Results (referrals)
Setting up procedures
Stop smoking
Support
Telephone advice
Throat swab

(Table 1b)

List of the components of the practice nurse's role identified by the GENERAL PRACTITIONER ONLY:
Audiometry
Emergency
First Aid (rural)
Minor surgery
Monitoring of patients
Spirometer
Tympanemtry
Wound dressing

(Table 1c)

As seen above in table 1b as compared to table 1c, there are some differences in what the practice nurses' and general practitioners' identified as the elements of the practice nurse role. It is interesting to consider that the practice nurses listed a number of tasks. The general practitioners placed their lists of tasks in categories instead of leaving them as lists. The practice nurses' list (1b) place an emphasis on administration elements of their work including the work which revolves around patient's results, and giving advice to patients, including telephone consultations. These were aspects of the role which the general practitioners did not suggest. In contrast the general practitioners recognised the emergency elements to the practice nurses' role. They also emphasised the more technical skills or tasks that make up the role, which the practice nurses did not mention.

In addition to the lists of tasks three main areas were categorised. The first of those was education, that is, education of patients in an array of situations, other health professionals and the education of the practice nurse themselves. Both practice nurses' and general practitioners' lists within this category resembled each other. The second category was described by practice nurses as tasks which were a list of activities they performed. The general practitioners, on the other hand, categorised the practice nurses' list of activities under the heading of "procedural". This raised a concern from one participant who did not wish for the practice nurses to *"feel"* that general practitioners thought practice nurses were proceduralists

> *but there are other parts of it as well. I didn't think that we should stress the procedures, you can certainly put the procedures down as core. I wouldn't like the nurses to feel that we thought that they were proceduralists.*
>
> (general practitioner)

This could be viewed both as a resistance and as a contradiction in two ways as highlighted in critical social science. First, the impression given by the general practitioner with reference to the role of practice nurses as one of "proceduralist" and the impact this could have as practice nurses became aware of this view at subsequent focus group meetings. Second, as practice nurses were initially set up in the 1970's in New Zealand to assist the general practitioner practice nurses at that time were required to take on those tasks or procedures *he* could delegate to the nurse. It is therefore understandable that the role of a practice nurse would be viewed by general practitioners as "proceduralist."

The practice nurses suggested a third category of "communication and support" which included a range of activities. These included visiting patients in the community, communicating in many ways about a number of issues and acting as a liaison person. On the other hand the general practitioners categorised their third list as administration which included a number of tasks practice nurses often perform in the general administration of the health centre.

As the practice nurse participants reflected on the written lists of their roles they seemed surprised (perhaps enlightened) at how broadly their role had developed over recent years and in particular, the diversity of their role. This diversity challenges the existing definition/description of a practice nurse as put forward by the College of Practice Nurses NZNO.

The definition presently describes a practice nurse as:

A Registered General or Comprehensive Nurse whose main focus is Practice Nursing in the delivery of Practice Nursing Services, working with a General Practitioner in the Primary Health Care Setting.

(NZCPHC 2000 no page number)

I believe the current definition restricts practice nurses to a subordinate role in relation to the general practitioner rather than them being seen to provide a complementary service. There has recently been a great deal of controversy and discussion amongst practice nurses surrounding the development of this definition in that it is seen to be too narrowly focused. This could be because in today's health climate the role of a practice nurse needs to be flexible and diverse. The role has advanced from the traditional doctor's assistant of the 1970's to a practitioner who has an array of skills that can enhance both the community and general practice. I believe a definition therefore, requires to be all encompassing of the diversity of the role rather than restrictive in nature. As long as the practice nurse works *with* the general practitioner and not alongside the delivery of health care and the autonomy of the nurse will be confined. As the focus group discussion progressed the consciousness of both the practice nurses and general practitioners expanded to include the prospect that the role of the nurse was no longer that of assistant to the general practitioner

> **it just amazes me because I've been around for a while and it really illustrates how our role with GPs developed beyond what it is now. I wouldn't have believed it when I started.**

(practice nurse)

Despite the recent advancement of the practice nurse role, there are a number of constraints that confine their practice and, ultimately, the delivery of health care in the General Practice environment. The focus group discussions (1A/2B, 2A/1B and 3) highlighted two main conflicting themes which may be the factors which oppress practice nurses from being

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complementary to the general practitioner. The two conflicting themes are first, that there is an assumption that the traditional role of the practice nurse is as an assistant to the general practitioner in contrast to today's view that the practice nurse provides a complementary role. Second, the fee for service versus a capitated funding system for the delivery of general practice services.

The first theme will be discussed below while the theme relating to fee for service versus a capitated funding system will be discussed in phase III (see page 121). Both themes are an amalgamation of the individual and collective focus group discussions.

ii)   *Practice Nurse Assistant Role versus the Complementary Role*

The themes associated with this category reveal that the participants had a degree of insight into the social processes which oppressed both the practice nurses and general practitioners. The following examples provide an account of how practice nurses are thought of as the "assistant" to the general practitioner. One general practitioner suggested that practice nurses are used as a "buffer" between the patient and general practitioner. This was seen as beneficial and protected the general practitioner from getting "caught up" with the patient and their health needs

> *I think most nurses spend a lot of time on the telephone passing messages of various sorts to patients...[the nurse also acts] as a buffer sometimes you don't actually want to get caught in a discussion on the telephone with a patient so the way that you avoid that is getting the nurse to pass the message rather than them coming in to see you.*
>
> (general practitioner)

It could be inferred from this attitude that the general practitioner's time and provision of health care is of greater importance, or had greater value attached to it, than both the

practice nurses and patients. However, from the following quote it can be argued that practice nurses were becoming aware (even enlightened) about their past and therefore changing their behavior accordingly

> **I can see where the handmaiden starts from and how work has been done by the practice nurses to become free and to perhaps dominate slightly to get where they are today**
>
> (practice nurse)

Practice nurses have been traditionally faced with constant interruptions to their work which could be another feature which oppresses their practice

> *I think that our nurses find one of the disadvantages is that there are always interruptions because you seem to be available and so the phone calls, the emergencies, the procedures... its hard to follow through on tasks without someone coming along and trying to get you to do something else*
>
> (general practitioner)

A third example highlights the lack of physical space for some practice nurses when providing patient consultations

> *space is a major problem...[for practice nurses] that you're getting somewhere private, quiet, where there is no phone*
>
> (general practitioner)

If this is the case and practice nurses do act as a "buffer," are interrupted, and have limited space for nurse consultations, it might be inferred their role is of lesser importance than that of the general practitioner. There appears to be a contradiction, as discussed by the following participants, who viewed the role of the practice nurse as complementary to the general practitioner

practice nurses get to know patients and their families but they get to know them from a different angle and so they will often know different things about the patients to us. The patients will tell them different things... it's sometimes really important things so they are quite complementary from that point of view

(general practitioner)

practice nurses are providing a parallel but different, rather than... I use the word "handmaiden" role which was sort of the original position of the practice nurse so that has been quite an attitudinal change that has taken place

(general practitioner)

These quotes illustrate an interest in a changing role for practice nurses in the direction of how their role complements the general practitioner. Acknowledgement of the practice nurses' original position as "handmaiden" highlighted by this participant and the corresponding acceptance of its current development is a positive move towards collaborative practice. However, the following quote implies that nurses are viewed as oppressed and demonstrates characteristics of an oppressed group in that the group itself takes on the values of its oppressors and becomes invisible (Miers cited in Wilkinson & Miers 1999).

I think, some GPs are very particular about what the practice nurses are to do.

(practice nurse)

This may occur when one group take on the values and beliefs of the oppressor and don't question them. Members of an oppressed group have views about themselves which are self-limiting (Miers cited in Wilkinson & Miers 1999). These views appear not to be based on the complementary understanding of teamwork. It is these views and assumptions that support my contention that practice nurses may have an oppressed relationship with the general practitioner.

A study undertaken by Stein and Madison (1967) examined the interaction between nurses and doctors. They imply that the relationship has been characterised by the stereotypical roles of doctor dominance and nurse subservience. Recent research undertaken by Williams (2000) came up with similar findings. This relationship can affect the care provided by nurses. Katzeman and Roberts (1988) sought to explain this phenomenon as being due to gender roles. What they discovered was that the subordination of the nurse's role often included the subordination of a nurse's professional judgment with regard to patient care. This situation can lead to problematic interaction, role identity and a lack of collegial relationships between nurse and doctor which feeds the subordinate relationship (Williams 2000).

However, in this research it would appear the nurse participants were aware of their lack of power and the restrictions which inhibit development of the complementary role of the practice nurse. This implies that practice nurses may adopt the attitude or belief that the general practitioner is the employer, and the leader of the team who takes complete responsibility for the delivery of general practice health care

> **at the end of the day the responsibility is theirs [the general practitioners'].**
>
> (practice nurse)

In fact practice nurses and general practitioners may both believe the "truth" that the practice nurse is the "assistant" to the general practitioner and the general practitioner the designated leader. Traditional ways of providing general practice health care by both practitioners may need to be changed for effective teamwork to develop. However, attitudes based on traditional values that the doctor is the leader and the nurse the assistant, may be grounded on regimes of truth and held onto by the dominant discourse (in this case, the

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doctor). If change is imperative to improve the team, then an attitudinal shift from both the practice nurses and general practitioners may be required. It is necessary for nursing and for the provision of health care in the General Practice setting that practice nurses overcome their uncertainties and work alongside general practitioners. It is hoped then that this collaborative relationship will benefit both professions and patient care.

It was refreshing to hear from the participants that there was agreement amongst them that the role of a practice nurse was changing

> **one of my observations and it might be wrong but I think that nurses are tuned into prevention**
>
> (practice nurse)

Likewise the following participant also felt there was an opportunity to utilise the practice nurses' skills

> *one thing that hasn't been touched upon is nurses moving into the clinical domain; in other words the diagnosis and treatment of illness... and to me there seems to be a great deal of potential there because a certain amount of my time is spent with fairly simple matters which I would rather not be dealing with and spending my time on - difficult ones where my skills are really used and you do wonder whether the nurses couldn't be filling the role of dealing with some of the more simple clinical problems*
>
> (general practitioner)

The quote from the above participant came from a capitated funding system, which is believed to promote a collaborative partnership between practice nurses and general practitioners. He/she thought that practice nurses should be providing, in particular, things that are "fairly simple matters." It could be argued that this is contradicting the aim of the capitation system which is to promote improved health care through the utilisation of the skills of the most appropriate practitioner rather than delegation of tasks. Perhaps this

particular general practitioner was suggesting that the practice nurse could be the more appropriate practitioner to provide these particular "simple tasks"?

These were the main themes, discussions and my interpretation on the topic question. The focus group participants later validated this interpretation (refer back to Chapter 4). The following focus group meeting is a discussion of the participants understanding of the roles/tasks of a general practitioner.

5.2.2   Phase II

Question: *What are the roles/tasks of a general practitioner as perceived by the practice nurses and general practitioners?*

Phase II focus groups consisted of two individual focus groups comprising of a group of practice nurses or general practitioners, which each met separately. This was the first time the general practitioners had met and was the second meeting for the practice nurses. The practice nurse focus group will be referred to as 2A, while the general practitioner focus group will be referred to as 1B. The following Figure 3 is a replication of Figure 1, with the shaded areas identifying the focus groups associated with this phase.

Practice Nurse   General Practitioner
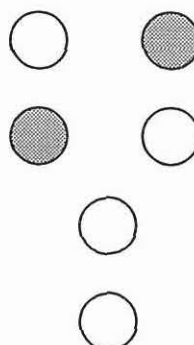
Phase 2 Focus Group Meeting (Fig. 3)

i)   *Focus groups 2A & 1B*

Focus group 2A consisted of five female participants. Focus group 1B was comprised of four general practitioners of which there were three females and one male. Both focus groups where asked to identify independently their perception of the role of a general practitioner for the provision of General Practice services in New Zealand using the "sticky paper" method as described in Chapter 4. As noted previously the "sticky paper" method was the first activity both these focus groups undertook before they discussed their thoughts on this topic. The method took approximately seven minutes, sufficient time for the participants to write down their understanding of the role. The lists are provided in the following tables 2a (p. 115), 2b (p. 115), and 2c (p.116). The first table (2a) comprises both of the practice nurses' and general practitioners' shared indications of what they thought comprised of the role of general practitioners. There are a number of items which the practice nurses only identified as the general practitioners' role and these can be found in table 2b. A third list of what the general practitioners' listed as their role which the practice nurses did not can be found in 2c.Both practice nurses and general practitioners individual lists contained similar components of the general practitioners' role as indicated in table 2a. As can be expected there are a number of elements which could be easily identified in association with the role. These include diagnosis, screening, prescriber and educator. In addition there are a number of other elements of the role which include manager of staff and running a business. To make sense of the complexity of this data I have summarised the core role of a general practitioner from both of the focus group discussions as:

> ***The core role of a general practitioner includes patient diagnosis, prescribing and education. This is combined with the elements of management, including running a business.***

The general practitioners' perceptions of their role is as follows:

The general practitioner's core roles include diagnosis and management of a patient's illness and the administration and employment of staff associated with their business.

The two perceptions are very similar, emphasising the diagnostic skills associated with the

general practitioner's role and their responsibilities for running a business.

List of the components of the general practitioner's role identified by BOTH GENERAL PRACTITIONERS & PRACTICE NURSES:
Advice / self care
Confidentiality
Counsellor / listener
Education / teaching
External legal forms
Health promotion / preventative medicine
Home visits / rest home
Liaison/networking with other health professionals
Peer review / support
Prescribing - medicine, treatment
Referrals
Screening
Staff management / management
Staff relations
Support families / terminal care

(Table 2a)

Lists of the components of the general practitioner's role identified by PRACTICE NURSES ONLY:
Advocate – patient
Appointment results
Audit
Cervical screening
Checks - childhood immunisation,
Checks - well man, woman
Chronic illness
Contraception advice / vasectomy
Disease management
Documentation research - writing environment, computer
Emergency treatment / trauma
Follow up phone calls
Minor surgery
Safe working environment

(Table 2b)

List of the components of the general practitioner's role identified by GENERAL PRACTITIONERS ONLY:
Teaching: students, colleagues
After hours care
Case discussion
Reassurance

(Table 2c)

As seen above in table 2b compared to table 2c there are some differences in what the practice nurses' and general practitioners' identified as what comprised the general practitioners' role. It is interesting to consider that the practice nurses listed a number of tasks that the general practitioner performs. These lists identified the different wellness checks that can be offered. These lists could have been categorised under the heading of screening which was listed by both groups in table 2a. There were some areas the practice nurses identified which the general practitioners did not, such as audit, emergency care, and minor surgery. There was one particularly interesting component that the practice nurses listed which the general practitioners did not that is, their responsibility to ensure that the working environment was safe. The general practitioners also found this interesting when they discussed each others' lists in the first joint focus group meeting. The general practitioners' lists of components of their role which the practice nurses' did not suggest are perhaps areas the practice nurses were not aware of, such as, teaching students and colleagues, after hours care, and case discussions.

Both the lists generated from the practice nurses' and general practitioners' focus group meetings resembled each other. The second category was described by practice nurses as "prevention" and the general practitioners as "counselling", both lists included a similar list of activities they performed within these categories. The third category was listed as

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"running a business" by the practice nurses which included a number of activities associated with this activity whereas the general practitioners described these activities as "administration" and were less descriptive about the elements associated with administration.

Two main themes can be drawn from these focus group discussions (2A & 1B). First, the role of the general practitioner and the changing relationships they have with practice nurses and patients. Second, the constraints felt by the general practitioners related to the fee for service funding system. These themes will be discussed in turn. The first theme will now be discussed while the theme relating to the fee for service funding system will be discussed in phase 111 on page 114. This theme will amalgamate all the focus group discussions which took place with relation to this topic.

ii)   *Changing Relationships between the General Practitioner, Practice Nurse and Patient*

The general practitioners agreed their core role had changed significantly over recent years. In particular, the added requirements for administration, liaison and expectations from patients were noted

> *expectations have changed, people expect more from you.*
>
> (general practitioner)

The participants were invited to discuss how they compensated for the changes

> *well, I have longer appointment times, it has changed to 15 minute appointments, a change from 10 minutes*
>
> (general practitioner)

I've tried to develop skills to get people to come back and carry on another day, which is very hard to do because we're trained to solve [the problem] it on the day which is fine if you've only got a couple of problems.

(general practitioner)

All participants expressed concern about the pressure that the current health funding system and ongoing health changes were causing which have made life increasingly difficult because of

insufficient time and limitations in a consultation.

(general practitioner)

The participants were invited to describe how they had adapted their role to accommodate these increased demands on their work. One suggestion included

get nurses doing more.

(general practitioner)

If this is the case then it would appear that practice nurses accept and offer services including medical tasks passed on to them by general practitioners. This is ultimately a sacrifice for the delivery of nursing health care as it reduces the value and specific contribution nurses can offer (Casteldine, cited in Hunt & Wainwright 1994). However, it was acknowledged that nurses

sometimes do it better than us [general practitioners].

(general practitioner)

Despite the above comment there appears to be resistance from general practitioners to encourage practice nurses to provide a broader health service. They accept the traditional "assistant role" of practice nurses, which mitigates against collaborative working relationships. Practice nurses have been traditionally associated with delegated work supervised by general practitioners (Williams 2000). It would appear that even though general practitioners are aware that collaborative relationships may improve practice,

provide benefits to patients, and improve the relationship between practice nurses and general practitioners they appeared resistant to the change. Resistance to change is an interesting concept as acknowledged by Fay (1975). There is an assumption that the relationship between practice nurses and general practitioners is based on collaboration and teamwork but in fact there is a power imbalance which is weighted towards general practitioners. The question remains, is this imbalance appropriate or desirable? Certainly it provides general practitioners with the power to control not only their own workload but also that of the practice nurse whom they employ. This tends to place the nurse in a subservient role causing difficulties for nurses to influence the actions of doctors. However, it is assumed by doctors that nurses will follow medical orders as has traditionally been the case (Williams 2000).

The historical role of a practice nurse as the doctor's assistant may have shaped the role of practice nursing as a task orientated helper for the general practitioner. Today's general practice health care environment requires interdependent members of the team who work collaboratively to enhance each other's roles and skills. I would argue that an employed nurse assistant is unlikely to have sufficient autonomy for effective teamwork. As general practitioners have taken responsibility for patient care they have tended to prescribe or oversee nursing treatments and closely supervise the care practice nurses provide to patients.

Tomkin-Greener cited in Colt (1998) has argued that general practitioners seem to see nurses as helpers and extenders. This encourages a form of teamwork in which nurses remain subordinate (Campbell-Heider & Pollock, cited in Colt 1998). However, nurses seek

a form of teamwork which encourages equity and collegiality with the doctor (Tomkin-Greener, cited in Colt 1998; Williams 2000). Medicine has gained the power to control nurses' provision of health care which is not in keeping with a collaborative relationship (Wilkinson & Miers 1999). A contradiction in terms (perhaps false consciousness) of what practitioners think they are doing and what is actually happening.

I invited the participants to describe what they considered was necessary to encourage an effective collaborative relationship between general practitioners and practice nurses

> **I think that it depends on your working relationship with your GP so that you know what each other are capable of doing.**
>
> (practice nurse)

The participants suggested working relationships could became effective through good communication

> **surely it would have to be the result of good communication and unfortunately that doesn't always happen.**
>
> (practice nurse)

However, there appears to me to be a contradiction between understandings and current practice. As expressed by the following participants they were concerned that resistance to effective communication and trust does not always happen and when it does it generally takes time to build up relationships with other practitioners

> *an advantage of the practice nurse role particularly where you have nurses who have been in a practice for a long time is that they just as a GP get to know patients and their families but they get to know them from a different angle and so they will often know different things about the patients to us the patients will tell them different things its sometimes really important things so they are quite complementary from that point of view.*
>
> (general practitioner)

> **particularly, I guess, if you are a nurse and you haven't built up any trust, you know. So it would be more difficult for the doctor to pass that responsibility on to his nurse until he has built up a trust to know that he/she is going to give the advice that he would have**
>
> (practice nurse)

The oppressive features of "responsibility on to his nurse" emphasises the subordination of this particular practice nurses' world view of the position of nursing relating to ownership by the general practitioner (a recurring theme in practice). This highlights the traditional differences associated with nursing and medicine relating to professional status and associated power (Williams 2000). If working relationships are impeded by a number of barriers then these differing views mentioned above may cause ineffective teamwork.

This is as far as this focus group discussion progressed. As described previously the participants later validated the main themes generated on these topic questions.

5.3.3 Phase III

Question: *Do you understand each other's role and function? What are the concerns about funding for general practice?*

Phase III consisted of amalgamating the focus group participants from 1A/2B and focus groups 2A/1B. This focus group will be referred to as the third focus group (Fig. 4 p.122). Focus group 3 was comprised of four female practice nurses and three general practitioners two female, one male. The following Figure 4 is a replication of Figure 1, with the shaded area identifying the focus groups associated with this phase.

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Practice Nurse   General Practitioner
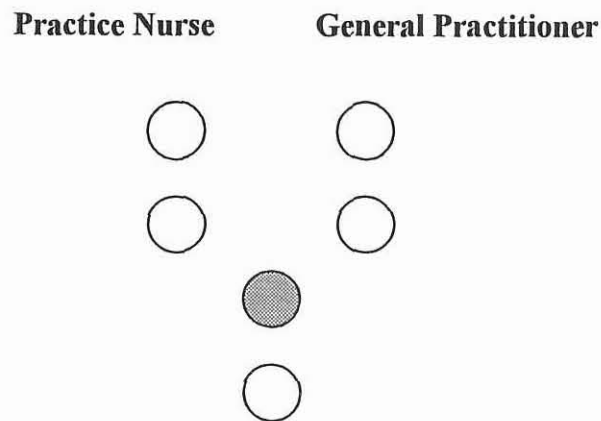
Phase 3 Focus Group Meeting **(Fig. 4)**

i) Focus Group 3

Focus group 3 was the first of two focus groups with both practice nurse and general practitioner participants. The meeting commenced with the participants acknowledging each other as they entered the focus group venue. This was the first time all the participants met together.

Prior to this joint meeting all of the participants had had the opportunity to validate their previous focus groups' themed transcripts. Additionally the participants had been invited to contact me by telephone prior to discuss any concerns with the transcript from the previous focus group meetings (2B and 1A). As this third group was an amalgamation of both the separate practice nurse and general practitioner groups, it would have been inappropriate and potentially unsafe for the participants (as suggested by the ethics committee) to have either group discussing the content of the previous focus group meetings together.

Prior to the commencement of this joint focus group meeting one participant rang me to ask how much of their focus group transcripts I was going to include for the other participants to read. I indicated that what I was going to send to all the participants were the themes drawn from the focus group meetings including the appropriate unidentified participant quotes to back up the themes. This satisfied this participant.

At the commencement of the meeting the participants were made welcome and invited to take their places according to their name badges which I had strategically placed on the chairs provided. This was to encourage the participants to mingle together. The chairs had been placed around a table where the participants could place and easily read the themed transcripts from each of the previous focus group meetings (1A/2B and 2A/1B).

The aim of this third focus group meeting was to provide the participants with a forum in which to discuss whether there were similarities or differences of their understandings and interpretation of each other's roles. The discussion was based on the information generated from all the four previous focus group meetings (refer back to tables 1a/b/c, and 2a,/b,/c, in this chapter). The discussion revealed that there was general agreement amongst the participants that they did understand their own and each other's role and function.

Common comments identifying the practice nurse role included:

> *The practice nurses lists seems to be more a list of tasks, whereas the doctors as there are, especially in the left hand column, there are some huge groups there which actually represent an enormous amount of work.*
>
> (general practitioner)

Its more of a doing sort of profession isn't it? Putting our skills into action.

<div align="right">(practice nurse)</div>

I wonder if there is a difference in the way the work comes to you in a day too, in that it comes to you task by task and you're less able to plan what you do whereas we [GP] might have a whole hour or two hours where we spend writing letters and doing administration.

<div align="right">(general practitioner)</div>

That's really a good point actually because I mean like the phone calls might come and we might do a task there and then and or somebody comes to us and says 'can you do this? well that's a task.

<div align="right">(practice nurse)</div>

I'm a little bit interested in one or two things in the nurses list that I realise that we do, but we certainly didn't think about the one I'm looking at at the moment - responsible for safe working environment and when I think about it, yes we are and yes, we do do things but I don't think any of us actually thought of that and so it perhaps highlights something that was more important to the nurses, than to us and so there's a possibility that if nurses weren't putting their hands up and saying, this has got to happen or we need this, it might not happen because we might not think about it.

<div align="right">(general practitioner)</div>

The acknowledgement of the general practitioner's administration role was also important.

I'm actually quite pleased to see how aware the nurses were of that part [administration] of our job because I think sometimes you feel as though it's a, it's a hidden part of your role that people don't actually realise how big a chunk of your life it takes.

<div align="right">(general practitioner)</div>

I think they have got a pretty good handle on it, [our role] and as I said earlier that whole business side of it that they are actually aware of that.

<div align="right">(general practitioner)</div>

This discussion brought to the attention of the participants the similarities and differences of their roles, and by this process the potential for enlightenment was created. However, on

reviewing the data it became clear that the roles identified were little more than a list of tasks. A number of other issues had been identified by the participants in the previous focus group meetings as posing a potential barrier to teamwork. This focus group meeting was used to stimulate further discussion and exploration of the impact of the socio-political context on teamwork.

Analysing roles can be associated with assumptions, assumptions based on societies' expectations. These assumptions can be based on professional, personal or historical social constructed values or beliefs. Differences as well as similarities including values, beliefs and ideas of both practice nurses and general practitioners need to be taken into consideration. Differences and similarities on one major theme generated from the focus group discussions will now be discussed.

ii)   *General Medical Service Fees versus Capitated Funding System*

The funding of general practice services had come up repeatedly in all previous focus group meetings. The context of the participant's discussions is included. I took the opportunity to use the remaining time set aside for this meeting to facilitate a discussion on this topic. The participants became aware that the current fee for service funding system of General Practice was a significant ingredient in the development of General Practice services. The following participant was conscious of the funding barriers to teamwork

> *funding is a barrier…historically there has been no payment*
> *unless the doctor saw the patient.*
>
> (general practitioner)

This requires the practice nurse to defer to the general practitioner for him or her to oversee nursing consultations so the GMS subsidy can be claimed.

the general practitioner feels that they have to see the patient a lot more than if it wasn't GMS funded.

<div align="right">(practice nurse)</div>

However, this is not always the case and general practitioners sometimes forgo the GMS because they

> *find it quite demeaning [to oversee the practice nurse's consultation] I would like to leave a lot to my practice nurse and I tend to and I tend to forgo the GMS because I find that it is such a demeaning situation.*

<div align="right">(general practitioner)</div>

> *because it can be embarrassing too, it's so embarrassing you know, while you're waiting the patients are given a nice magazine to look at.*

<div align="right">(general practitioner)</div>

The current GMS fee for service funding for General Practice services has implications for the way General Practice services are delivered and by whom. The problems identified by the participants throughout the focus group meetings included a number of perverse incentives associated with the fee for service funding system. A capitated fee structure for General Practice services allows the most appropriate health professional with the appropriate skills to provide and generate fees for the services provided. Whereas the GMS funding is payable to the general practitioner only. The capitation funding system has the potential to reduce, but does not altogether remove, the initiative for general practitioners' oversight of each patient consultation with the practice nurse. Differential co-payments for seeing the general practitioner versus the practice nurse still leaves a perverse incentive for the patient to be directed towards the general practitioner rather than the nurse. This is on the basis of traditional practice and the generation of patient subsidies rather than clinical appropriateness. The participants believed that the capitation funding partially removes these barriers.

It is interesting to consider why the GMS subsidy is not available for services provided by the general practice team. If the GMS subsidy could be claimed by other team members generating income for the practice this could foster teamwork and encourage the general practitioner to be more inclined to share patient follow up consultations with the practice nurses. This has been shown in New Zealand to be of benefit to patient care and results in better patient compliance (Reid and Anyon 1987). In addition, a collaborative approach between general practitioner and practice nurse could free up some valuable and scarce medical time. Continual oversight of practice nurses has clear implications for their autonomy (Carson 1998; Toop 1998a) and subordination of their role and delivery of health care

> **you don't get seen to have autonomy if you continually [have someone] looking over your shoulder.**
>
> (practice nurse)

There was agreement amongst the participants that the practice of a general practitioner overseeing a practice nurse's patient consultation was not only professionally inappropriate, but also a waste of time for patients and, degrading for the nurse. Both practice nurses and general practitioners indicated their frustration at this barrier brought about by the current GMS fee for service funding system. However, there was some resistance by the general practitioner's to change the status quo.

The fee for service funding for General Practice services has implications for both the practice nurse and the general practitioner as expressed by the following participants

> *the system has developed the income is constrained. [The current fee for service funding] is an advantage for the doctor and a disadvantage for the nurses*
>
> (general practitioner)

Both practice nurses and general practitioners were aware that the general practitioner is responsible for generating all of the income for the practice

> *they [practice nurses] are not having to generate income the same, yes they can generate income but it's not so critical that they get an x amount of income an hour.*
>
> (general practitioner)

However, instead it could be that the general practice team could have the responsibility to generate income for the practice

> *practice nurses can generate a fairly reasonable income themselves if allowed to charge suitably for their services.*
>
> (general practitioner)

This conversation perhaps offered the participants an opportunity to reflect on and change their beliefs about practice nurses not needing to generate income within the practice. In addition the capitation funding could allow for the essential elements of teamwork to flourish as this particular participant implied

> *[capitation] has meant that there seems to be more fairness in the way the money comes in...you're not losing money by your nurse seeing a patient...whereas before [with a fee for service] if you stopped to think about it there was actually a financial loss.*
>
> (general practitioner)

This implies that practice nurses would then have an opportunity to work in an autonomous role complementing the general practitioner functions

> *I think that capitation [has] advantages in giving practice nurses more freedom and autonomy to see, see patients without their doctor having to cast an eye over them.*
>
> (general practitioner)

The capitition system in turn assists the general practitioner by providing

> **a lot more time for general practitioners to actually spend with their patients that actually need a general practitioner.**
>
> (practice nurse)

General practitioners throughout New Zealand have been slow to take up this opportunity

to become capitated despite the opportunity and encouragement from the government

> **I mean it's a farce with the GPs at the moment... I would
> love to see that removed [fee for service] but there seems
> to be a lot of resistance to capitation.**
>
> (practice nurse)

The participants were aware of the constraints but were resistant to accept the current

context and regulations set down by the funding authority for the GMS funding system, and

the effects this could have on their own and practice nurses' work.

> *I'm quite open - either charge the patients or wait and get
> GMSed; it's up to them because we are not capitated. If you
> sort of try and hide from patients the fact that it is financial,
> then that's embarrassing. If you explain to them the system
> imposed upon us then they get used to it.*
>
> (general practitioner)

> **I think that's quite true, I mean, I think you know people
> are quite honest - what's the point of lying to someone
> and if they make the choice of wanting to stay or go they
> make that choice, but it is sad that they have to make that
> choice when it was probably only you didn't actually need
> to really see that patient.**
>
> (practice nurse)

There was little resistance from the general practitioners to make a change. However, this

was not the case for the practice nurses who were not only aware of the oppression these

regulations place on their practice but also expressed their resistance to it

> *its quite demeaning sometimes when you have got to sit
> around and wait for a GP to come free so that they can see
> the patient.*
>
> (practice nurse)

If the barriers which affect the practice nurses' role are not challenged, the nurses role as

assistant to the general practitioner will preclude collaboration and the appropriate

utilisation of nurses for community health care (Carryer et al 1999).

This discussion highlighted (raised their consciousness) for the participants the problems of the fee for service system which could be overcome, in part at least, by changing to a capitated funding system as expressed by this participant

> *for us it's [fee for service] no longer a problem but for many*
> *people funding is a barrier as well because historically there*
> *has been no payment unless the doctor saw the patient.*

(general practitioner)

The participants expressed their concern with the funding system, I invited them to highlight what the frustrations were. This discussion led onto looking at an alternative funding structure specifically for practice nursing in General Practice

> **we've got a budget, in the nurses' budget you see and this**
> **is what they've got to bring in and this is the money we've**
> **got to spend it on, supplies, or miscellaneous things on**
> **education, on uniforms, on nurses' wages and the**
> **[practice nurse] subsidy goes into that as well, it works**
> **really well.**

(practice nurse)

> *has that altered the way you all feel about charging?*

(general practitioner)

> **yeah, it's the same with nurses trying to gain autonomy**
> **and gain their own professional status, if you're not**
> **charging them [the patients], you're not saying hey, I've**
> **done 3 years or I've done my degree or I've done this, you**
> **know.**

(practice nurse)

There was an apparent contradiction amongst the participants about the funding and continued resistance from the general practitioners who provide general practice services on a fee for service basis. The general practitioners became aware of the implications the numerous barriers with the fee for service funding model compared to the potential advantages a capitated funding system could have for their own and the practice nurse's provision of health care and the potential inconvenience for patients.

This is as far as the participants discussed this topic. However, there appeared to be a continued resistance (Fay 1975) from general practitioners to change from a fee for service funding system to a capitated system. This is despite the numerous barriers with the existing funding model and the potential advantages a capitated funding system can provide which could benefit teamwork.

5.2.4 Phase IV

Question: *Is there a difference in role and function for the practitioners in general practice?*

Phase IV will be referred to as focus group 4 which comprised of one practice nurse and two general practitioners. All of the participants were female.

Figure 5 is a replication of Figure 1, with the shaded area identifying the focus groups associated with this phase.

Practice Nurses   **General Practitioners**
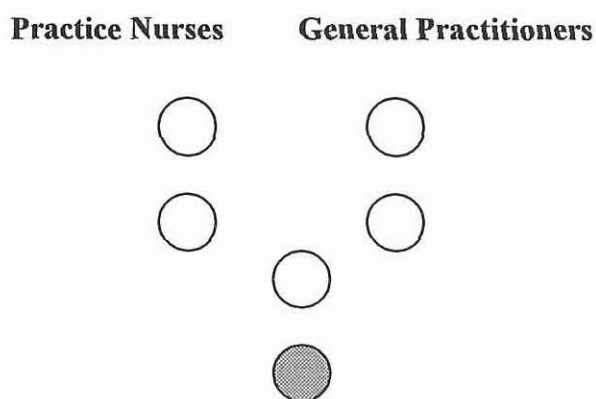
Phase 4 Focus Group Meeting (**Fig. 5**)

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i) Focus Group 4

Even though only three participants attended this focus group meeting I decided to proceed with the meeting and not to cancel it. The participants had met each other at the previous focus group meeting and had begun to build up a trusting relationship. I was therefore not concerned that a small number of participants would raise any problems for the discussion as predicted by Morgan (1988) and Krueger (1994).

One of the aims of the focus group meeting was to bring closure to the research. Closure consisted of two elements; first to provide the participants with a sense of completion of their contribution to the research. Second, to invite further discussion on a significant part of the research that I believed required further discussion.

The themes which developed from the previous focus groups, in particular focus group 3, brought to my attention that there was one main unanswered question. I wished to offer this to the participants for further discussion. The question that remained unanswered was that there appeared to be confusion in the research literature between role and function. I observed this when reading the literature relating to the definitions put forward by a number of leading researchers on teamwork. The literature places different emphasis on the necessary requirements for effective teamwork. These include the understanding of each individual team member's *role* (Thomas & Corney 1993; Pritchard & Pritchard 1994; Colt 1998). In contrast other definitions implied the importance of understanding each other's *functions* (Gilmore, Bruce & Hunt 1974; Poulton & West 1993). I was confused, so I prepared an information sheet comprising information on a variety of teamwork and role

definitions (see Appendix 10). These definitions were offered to the participants to stimulate the discussion.

Indeed, the participants' initial reaction was that they could not see why it would be of concern. The participants were invited to discuss whether they perceived a difference between the "roles"of practice nurses and general practitioners beyond the sum of the tasks they performed. The participant's initial opinion to this question was that there was no difference.

ii) *Roles & Functions*

The discussion continued with a participant debating whether there was a difference between role and function

role is what you are, and function is what you do.

(general practitioner)

As the discussion unfolded it became clear to the participants why I saw a dilemma. As the participants further discussed and brainstormed the issues of role and function I captured their discussion on the whiteboard. The focus group discussion led to the development of a concept of role/function as depicted in Figure 6 (p. 134).

Socio-political context

Role

Function   Attributes

Tasks of action for   Professional   Personal
a specific purpose

Behaviour   Training   Intrinsic   Acquired
               Value systems
Expectations   Beliefs   Personality   Learned
               Philosophy   Leader   Cultural
                           Carer   Heritage
                           Follower   Skills
                                      Knowledge
                                      Attitude
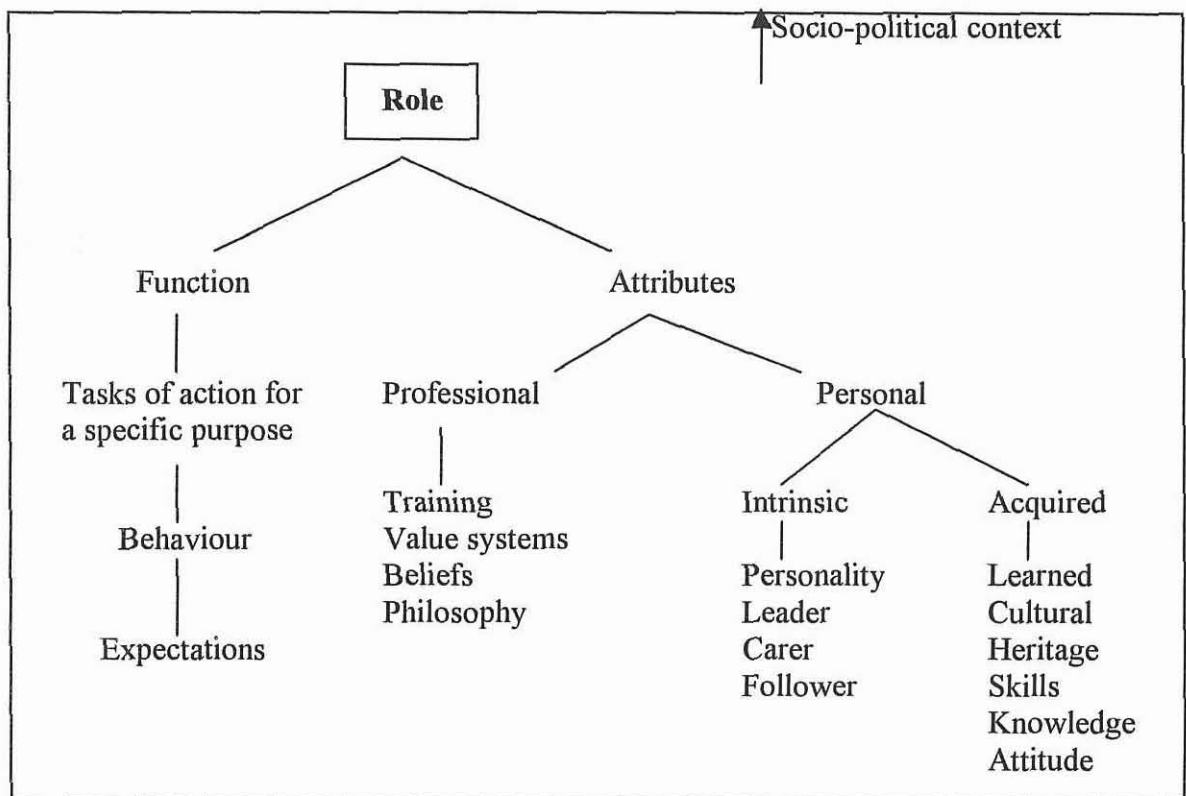
Elements associated with role (Fig. 6)

Figure 6 provided the participants with a visual image of what they were discussing. As the discussion progressed the participants' understanding of role further developed. Role was a focal point of their discussion and they identified a number of connecting elements which made up "role". The participants emphasised that there were two main elements to role, functions and attributes. This can be associated with enlightenment, an essential element of Fay's critical social science framework. The following is a summary of the participants understanding of the elements which are associated with a role.

An individual is socially constructed within a role. Role generally has social expectations associated with it. The expected components of role as put forward by this group are *functions* and *attributes*. Functions is the behaviour associated with the role

it is what is expected of you in that, in that role

(practice nurse)

the function comes from the role, the function is behaviour.

(general practitioner)

The participants then commented on what makes up the attributes of a role. Attributes can be divided into two areas, that is intrinsic attributes such as personality or acquired attributes which can be divided into three areas, knowledge, skills and other personal acquired attributes such as experience and attitude

the role is what people perceive you to be doing, how you actually function within that role are the attributes I suppose.

(practice nurse)

intrinsic attributes are something that you are born with.

(general practitioner)

The participants put forward the suggestion that intrinsic role attributes can be influenced by an individual's personality

your personality characteristics are sort of the prerequisites [of how an individual will perform in a certain role]

(general practitioner)

These attributes may be associated with the individual's cultural or historical background

it's your cultural heritage isn't it really it is the individual that comes from your cultural or historical perspective.

(practice nurse)

attributes could be personality characteristics or they could be learned skills, learned knowledge.

<div align="right">(general practitioner)</div>

The participants were becoming aware (even enlightened) of the complexities that make up

the elements of role

> **I don't think that it's just actually the role, I think it's the understanding of the person you are working with as well.**

<div align="right">(practice nurse)</div>

> *I can see what you mean. By understanding the roles and by understanding higher things like values and beliefs which are not necessarily manifest; when you look at someone's function it is like what's behind the behaviours which give a much deeper insight.*

<div align="right">(general practitioner)</div>

The discussion was enlightening for me and assisted my understanding further on the topic.

I became aware of the suggested and potential differences of role and function and the

implications this may have on teamwork

> *the problem with understanding the function and the role is that there maybe people with unexpected, particularly perhaps, intrinsic attributes which are not valued or used.*

<div align="right">(general practitioner)</div>

The participants indicated that the traditional values and expectations placed on individuals

within a role oppress or constrict their behaviour to perform in a particular way

> *say if you have a nurse who is by nature a shaker and a mover but because that is not perceived to be her function then that attribute is not used and valued within the team as a whole.*

<div align="right">(general practitioner)</div>

> *there's an historical difference in that traditionally the doctor was the leader and the nurse was the follower and the nurse, probably historically, was more the carer but that is*

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changing and that is part of the modern tension I think. So it matters in the context of what is happening today.

(general practitioner)

The discussion progressed as this participant emphasised

well basically when you want somebody else to join your team you've got to have a perceived role but then you have got to identify the functions that you want that team member to perform within the team, within the role, so it's not just OK to say I want a practice nurse, you have got to say I want a practice nurse to be able to do these functions.

(practice nurse)

However, in reality

if you don't have an open mind about what the role might be, you might define it too narrowly.

(general practitioner)

The participants appeared to raise their consciousness of their previous thoughts or beliefs

on role and function

I suspect understanding team member function is much better than not doing that and I think that's helpful but having an understanding [of] role is even better...

...so it's like understanding role goes a bit further.

(general practitioner)

As highlighted previously role has been constructed by society and can be illustrated as a circle as shown in Figure 7. Role consists of the behaviours, values, expectations and beliefs associated with the performance of the role.

Personal attributes
(person)

ROLE
(social construction)
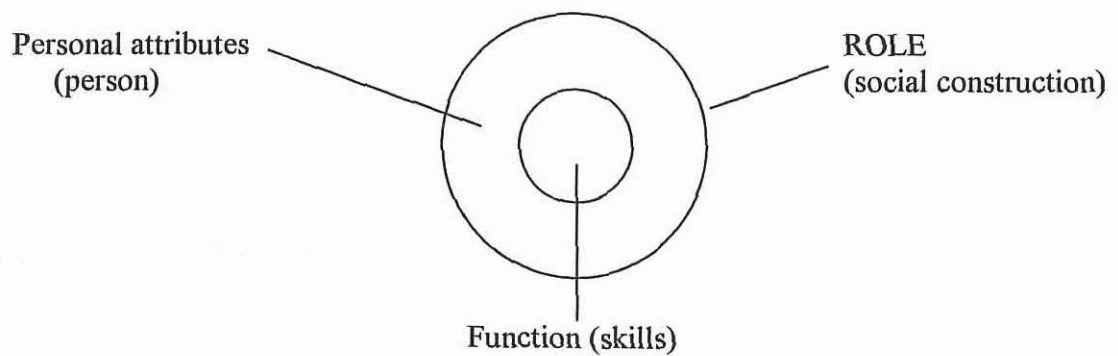
Function (skills)

The components of role (Fig. 7)

I suggest that functions are therefore a subset of role. I contend that role is more than function, with its associated skills and tasks. As the role remains consistent, it is the performance of the functions associated with the role that becomes unique to the individual person. It is how the person performs the functions and their personal attributes or persona that are unique to that individual which differentiates between individuals and their performance and outcomes. This concept will be discussed further in the next chapter.

This is as far as this meeting progressed on this topic. The meeting was very relaxed with a challenging discussion provided by the participants who did not require a great deal of facilitation. These ideas were later validated with the participants by mail. This was the final focus group meeting.

5.3   Conclusion of Chapter

The interpretation of the data was a continual evolving process throughout the research. A descriptive account of all themes, ideas and conclusions assisted the critical analysis. An interpreted account of what was discussed from each of the focus group transcripts was generated from the focus group meetings. The first four focus group meetings generated lists of components of either the practice nurse or general practitioners' perception of their own or each other's role. The data generated were specific to the views and opinions of each discipline. At this stage neither the practice nurses nor the general practitioners had heard or read any material associated with the discussions from each of the other focus groups. This exercise highlighted to the participants what the core tasks and role of a practice nurse and general practitioner were. It also identified the effect the current funding sysrem was having on team members and the provision of health care. This gave the participants the opportunity to discuss the funding of general practice services. The final focus group meeting invited the participants to discuss if there was a difference between health practitioners' roles and functions. By feeding the themes back and making these available to the participants, the potential has been created for emancipation. However, emancipation is one element I did not consider would occur within the time allotted for this research. Emancipation according to Fay (1987) would require a critical social researcher to work collaboratively with the participants over a longer period of time than this research would allow. The following chapter will interpret role and function, reflecting back on the aims of this research.

CHAPTER 6
Interpretation of Role

6.1 Overview of Chapter

The intention of this chapter is to offer my interpretation of the data collected in the focus groups. The main aim of the research was to examine the understanding of role by practice nurses and general practitioners. The intention was to see to what extent these two groups understood each others' contribution and roles. This interpretative journey has been guided by Fay's (1987) critical theoretical framework. This framework has highlighted the examples of false consciousness, resistance and enlightenment which I would argue the participants experienced through their discussion on their understanding of roles and function. Participating in this research may have assisted the practice nurses and general practitioners to develop alternative ways of understanding their own views and beliefs of role, in the light of the social context in which they work. The perceived differences between "role," "function" and personal attributes will be discussed in the light of the contextual effects of power, knowledge and values associated with the practice nurses' and general practitioners' understanding of their roles as it relates to the General Practice setting, in particular, in New Zealand. Arising from the research is a proposal for a single model (framework) of General Practice teamwork. Research has shown (Gilbert, Camp, Cole, Bruce, Fielding & Stanton 2000) that practitioners do not feel prepared for effective interprofessional teamwork and that there is no framework relating to teamwork, to assist them in their journey. This model incorporates a number of essential components for effective teamwork which have been agreed upon in the literature (Katzenbach & Smith

1993; Poulton & West 1999; Williams & Laungani 1999). One of these components relates to role which will be discussed in depth within this chapter.

6.2 Interpreting the Research Findings in Association with Role

My assumption at the planning stages of this research was that practice nurses and general practitioners did not fully understand each other's roles. This lack of understanding has been highlighted as one impediment for successful teamwork. My assumption from past clinical experience and the numerous references in the literature (refer back to Chapter 2) relating to teamwork and the problems associated with its success, had been reinforced. The number of participants who contributed in this study was small. However, they were enthusiastic about the research and the topic and recognised the benefits effective teams could have for the delivery of General Practice services. In reality, the value of the research lies in each person reading it and saying, "yes that is true for me".

Focus groups were chosen as the most suitable qualitative method to generate open discussion for this research. This medium provided the participants with the opportunity to describe, listen and discuss with each other their beliefs and opinions of their own and each other's roles. I have used Fay's (1987) critical theoretical framework to interpret the data. Using a critical approach, has not, as far as I can tell been used in research pertaining to teamwork within the General Practice setting in New Zealand. I was interested to observe whether the elements of Fay's (1987) critical theoretical framework; false consciousness, resistance, enlightenment and emancipation, could be applied to the data generated from focus group meetings. Participating in this research may have raised the awareness of

practice nurses and general practitioners which, in turn, exposed their assumptions of their roles and the barriers and social context in which they work. As situations are exposed through critique then consciousness may be raised. I believe this did occur and provided the participants with an opportunity to look at their situation and broaden their perspectives on another view. The participants were then in a position to question their taken for granted perceived assumptions and beliefs. This, in turn, led them to be in a more informed position (Fay 1987). The participants were then able to analyse the gaps and ambiguities associated with role which may act on the barriers to successful teamwork. It is hoped that such new understandings will act as the catalyst for future developments or alternative working models for the core primary health care team members. This has been the driving force of this research. In this respect I believe my original aim has been, at least partially, achieved.

6.3   Roles for General Practice Teamwork

It is now timely to submit role to analysis and interpret the participants' discussions and describe how this research has influenced my own understanding of the importance of role identification in effective General Practice teamwork.

Nurses and doctors have roles which are socially recognised and supported by their professional bodies (Scott 1995). Therefore, given that health care practitioner's function in roles recognised and supported by society and the professions, a more detailed analysis of the concept of role may give some insight into the nature and requirements necessary for effective teams. The undertaking of this research has raised my consciousness in that role is a multilayered, complex construct. I believe a more detailed analysis of role is necessary in

the context of teams. This is because it could be argued that the very construction of role, (as described in Chapter 2) may have a constraining affect on creative teamwork. Role consists of a number of elements (false consciousness) which place an expectation of behaviour on individuals to conform appropriately (Downie 1971; Gilmore, Bruce & Hunt 1976). Roles have a number of expectations, made up of values, beliefs and opinions held by society and by individual disciplines. Health care practitioners become aware that they are entering recognised roles early on in their training, which carry implied duties and responsibilities.

it's what is expected of you in that role

(practice nurse)

By adopting the role of a nurse or doctor the individual is actually accepting these implied duties and responsibilities. There is, therefore, conscious awareness of being in a role (Downie 1971).

Professionals are socialised into their role which can be discussed openly or at times covertly. Professionals learn the expected behaviours of the role through professional training, role models and mentorship. The core components of a role are associated with the image of the profession. Once a role has been established, it usually remains. It may be difficult to shift the publics and professionals' assumptions, attitudes and expectations associated with role. Disagreement can arise amongst health care providers when behaviour associated with that role is not adhered to. These disagreements may result in conflict although healthy differences can, and should exist amongst team members. Differences must be handled in a constructive way otherwise the benefits of teamworking are greatly diminished (Poulton & West 1999). Individual participation is one element which has been

identified by Poulton and West (1999) as necessary for effective teamwork. However, if an individual team member withdraws from the team and is not participating openly, in a positive supportive environment, the individual may became less functional. This could have devastating effects for the individual as expressed by Maslow (1954).

Maslow has put forward the notion that individuals are unable to function in an environment that is not conducive to self-actualisation, unless they are fed emotionally and spiritually. I argue that Maslow's notion can be adapted for the needs of effective team and teamwork. West (1994) suggests it is necessary that new and improved ideas for improving health care by individual team members are supported. Innovative thinking from team members is essential if the team is to be forward thinking and effective. I believe that in today's health care climate we need to get past the traditional stereotypical roles of the general practitioner as leader/employer and the nurse as the assistant/follower/employee.

> *There's an historical difference in that traditionally, the doctor was the leader and the nurse was the follower the nurse probably, historically, was more the carer.*
>
> (general practitioner)

Therefore, it could be argued from the responses of the practice nurses and general practitioners in this study that such an understanding of the historical identification of role is in itself, a barrier to teamwork. It appears that there are a number of different elements to role. I will consider the leadership and personal elements of role which may provide us with a more informed understanding of the components which it comprises.

Leadership is important for effective teamwork (Ross 1989). Every team needs a leader. Leaders need to have the vision and energy to ensure the goals of the team are decided

upon, are met and that the team is on track. Leaders use this vision, passion and energy to instil enthusiasm in the rest of the team (Poulton & West 1999). However, contrary to traditional belief, leaders' skills are not confined to a specific discipline so therefore are not discipline dependent

> *say if you have a nurse who is by nature a shaker and a mover but because that is not perceived to be her function then that attribute is not used and valued within the team as a whole.*
>
> (general practitioner)

The above quote illustrates the traditional values and expectations placed on nurses. Nurses are not seen as leaders of the health care team. It could be argued that teamwork would be more effective if each team member paid less attention to the identification of specific discipline roles. This concept challenges the traditional way of thinking (Downie 1971). The implication is that attention may then be given to understanding their own and each other's functions for effective teamwork.

The participants who contributed to this study did, in fact, appear to have a good understanding of each other's day to day professional functions and tasks. However, the participants became aware through discussion that there was more to their clinical "roles" than simply the sum of the tasks or functions they performed

> *role is what you are and function is what you do.*
>
> (general practitioner)

This led me to consider perhaps role, as compared to function, is more complex and necessitates further research than has previously been undertaken. The personal attributes that individuals bring to their role have generally not been included or highlighted in the traditional teamwork definitions in the literature (Elwyn-Jones, Rapport & Kinnersley

1993). The current definitions of teamwork emphasise there are numerous components necessary for effective teams, in particular those associated with role or function. These definitions seem to highlight that one essential element for effective teamwork is to understand either *"role"* or *"function"* implying that they are interchangeable. This is illustrated in the following two quotes:

> *Each member of the team has a clear understanding of their*
> *own functions, appreciate and understand the contributions*
> *of health professionals and recognises common interests.*
>
> (Gilmore, Bruce & Hunt 1974 p.7)

In contrast Pritchard and Pritchard (1994) state:

> *Each team member must have a clear perception of their own*
> *and must be aware of each other's role.*
>
> (p. 46).

These separate definitions imply that "role" and "function" have been given the same weighting as essential for teamwork. If this is the case, then these two definitions could be interchangeable. However, I will argue that "role" and "function" are not the same. Participation in the focus groups brought to the practice nurses', general practitioners' and my own consciousness, the hidden or unconscious concepts of functions performed within a role. Unconsciousness, as expressed by Fay (1987), is a false consciousness in which the participant's opinions, values and behaviour are constructed to conform to the expectations of both society and their individual disciplines. Taking this into consideration may impede team members from exercising their individual skills and performing the functions necessary for achieving effective teamwork. I would argue that understanding individual team members' skills, personality and attributes in addition to functions are all necessary for effective teamwork

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well basically, when you want somebody else to join your team you've got to have a perceived role but then you have got to identify the functions that you want that team member to perform within the team, within the role, so it's not just OK, I want a practice nurse, you have got to say, I want a practice nurse but I said the practice nurse needs to be able to do these functions.

(practice nurse)

if you don't have an open mind about what the role might be, you might define it too narrowly.

(general practitioner)

These statements imply that this could have destructive implications for the team's performance. I argue that the identification of perceived functions is essential for effective teamwork, rather than conforming to perceived traditional roles as discussed previously

yeah, as I was thinking about that overlapping circle that that focus has tended to be on nurses wanting to be doctors and you know nurses are trying to expand their roles, but in fact doctors have moved into nurses' territory by becoming less authoritarian, more caring...

(general practitioner)

...because initially my response was that nursing seems to be expanding more into our role but you are quite right, it's a two-way thing.

(general practitioner)

Perhaps traditional perceptions and expectations of professional roles, that of the doctor as the leader and the nurse as the assistant may impede both the personal and professional development and function of all members of the team. This could have a corresponding effect on team effectiveness and the performance of individual team member's contributions.

I would argue that there is always a personal element to role. This includes a blending of role and personality, a presence of attributes additional to the constructed expectations

placed on a role by society. The personal attributes, which a person brings to a role, may or may not influence the actualisation of the role. The role is still functional, however, it is often the personality dimensions or personal attributes of an individual which result in different outcomes and behaviour between people in similar roles. As individuals demonstrate different ways of achieving the same goal (Downie 1971; Sims 1986) the personal elements or attributes which comprise part of the individual need to be recognised for their importance and the effects this can have on the team's performance

> *your personality characteristics are sort of the prerequisites*
> *of how an individual will perform in a certain role*
>
> (general practitioner)

If this is the case, then all members of a team need to take into consideration the importance of working towards fulfilling each individual member's personal goals and aspirations. Incompatibility between personal and professional expectations may result in unhappiness for both the individual, and the team. Individuals need to grow and be sustained both emotionally and spiritually in order to achieve a high level of self-esteem (Maslow 1954). One way this may be achieved could be for team members to acknowledge, understand and utilise each other's skills and personal attributes. Clearly, roles are not just about rights and obligations defined by society and professional bodies. The additional hidden personality dimensions are too often forgotten (Pellegrino, cited in Scott 1995) which the participants came to realise were part of their role

> *the problem with understanding the function and the role is*
> *that there may be people with unexpected, particularly*
> *perhaps, intrinsic attributes which are not valued or used*
>
> (general practitioner)

> **the role is what people perceive you to be doing, how you**
> **actually function within that role is the attributes I**
> **suppose**
>
> (practice nurse)

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Attributes therefore, may enhance team goals and performance and likewise if used effectively, may enhance individual performance.

If individual team members' attributes and strengths are not valued and acknowledged then frustration, lack of commitment and ultimately, inefficient teamwork is likely to result (Hardy & Hardy 1988). If this is the case then individual team members may look to another area of their life for their personal needs and satisfaction to be met (Maslow 1954). However, it could be suggested that more time and energy would be focused on individual fulfillment rather than the team's common "vision" or overall goals. This could reduce the performance of the team, while the individual team members may suffer as a consequence. A balance of personal and professional satisfaction would be an obvious way forward.

6.4   Final Comments

To reiterate, the research aim was to gain a clearer understanding of practice nurses' and general practitioners' perceptions of each other's roles in the belief that this would assist in improving teamwork for the practitioners in the General Practice setting. The research aim was addressed through three main themes. The first theme set out to explore practice nurses' and general practitioners' understanding of their own roles. Second, to explore practice nurses' and general practitioners' understanding of each other's roles. Third, to enable practice nurses and general practitioners to gain new understandings of each other's roles within an expanded primary health care service in general practice. The aim of the research had a profound influence on my decision to use a qualitative approach to generate data. My aim was to gain a clear and more open understanding of the research topic while

taking into consideration the context in which the participants worked. I hoped this would support the idea that the lack of understanding of role was indeed a barrier to teamwork. My assumption was that there could be elements of the practice nurses' and general practitioners' roles about which the other group was not aware, or about which they lacked understanding. I wished to explore both the overt and the covert factors which influenced the participants' understanding of their practice and beliefs of role.

I am pleased that I chose a critical social science framework to explore role. This allowed both the participants and myself to begin to uncover and tease out the components which influence role, beyond the traditional lists of functions. It has also assisted to guide this research and place the data within the socio-political context of New Zealand's General Practice setting. The intention of this research was to raise the awareness of the research participants' own and each other's roles for the provision of General Practice. Raising their consciousness was guided by Fay's framework, allowing the participants a safe environment to share and hear other's beliefs and raise their own awareness. In addition, this approach may have exposed and demystified the ideologies which could have distorted their own behaviour and beliefs. Just what participants do with this knowledge could either be advantageous or disadvantageous to them and/or their work colleagues. However, with a framework in place to guide the participants within their own socio-political environment it was hoped this knowledge would support the participants. It is for this reason that I choose to use Fay's (1987) critical social science framework. This framework guided the whole research process commencing with the planning, ethical approval, developing a relationship with the participants, holding the focus group meetings, collection of dialogue, analysis of the discussions and the writing up of this thesis. The aim has been to protect the

participants whilst contributing to this research, as problems or issues relating to the research could have been raised during the discussions at the focus group meetings and continued on into the participants own clinical practice.

In conclusion I found that my original assumption at the commencement of this research was that practice nurses and general practitioners did not fully understand each other's roles was invalid. However, my interpretation of the data that was generated throughout this research highlights that the understanding of "role" is not as easy to understand as suggested throughout the literature pertaining to teamwork. "Role" is a complicated construct and comprises both the traditional concept of "role" and the modern interpretation of "function". In conclusion of this research I suggest that the understanding of role impedes effective teamwork, and instead it is necessary to understand team members functions and to value each and every team member's contribution. This may be achieved by utilising the most appropriate team member with the necessary skills and attributes for the given task.

6.5   Where to from here?

I believe the barriers to teamwork highlighted by this research, whilst well recognised, remain contentious for both practice nurses and general practitioners. As the increasing demands to care for a diverse population will fall on the shoulders of the core primary health care team, the need for effective teamwork will be greater than ever. Primary health care teams, together with local community involvement, will be increasingly involved in identifying health needs, planning, coordinating, delegating, delivering and measuring the

provision of health care. Team members will require a better understanding of how teams function. This will, in turn, require greater awareness of the value of roles and responsibilities and will hopefully provide those involved in the delivery of General Practice services with a healthy and positive attitude. If this is to be the case, health care practitioners will be required to acknowledge the impact this will have on their role and look to their own and others' personal attributes and team for performance.

I believe this research has demonstrated that the current GMS fee for service funding for General Practice, the current practice nurse subsidy and the employment of practice nurses by general practitioners all contribute to the difficulties in developing collaborative teamwork. Perhaps one way to partially alleviate these difficult barriers would be for all primary health care providers in New Zealand to be employed (salaried) by the newly appointed District Health Boards (DHB) or Primary Care Organisations (PCO). The end of 2000/ early 2001 will establish the DHB's and PCO's. These organisations could break down the difficulties which have been identified above. This new direction would require collective responsibility between the New Zealand Government, DOB and PCO's, health care professionals and communities working collaboratively with a common goal to improve health care. These organisations would, amongst a number of additional responsibilities provide national and regional health objectives; require primary health care teams to monitor their contributions; employ the most appropriate members of the team to provide the services, based on to their abilities rather than their specific disciplinary backgrounds.

The interpretation of this research suggests first, the concept of role identification is an impediment to successful teamwork. Second, the personal attributes of team members need to be explored, accepted, and utilised for effective team performance. If personal attributes of individual team members enhance team performance, then further research exploration will be necessary to see if this will add any weight to team performance. Additionally, if this is the case, it will be necessary to understand how this concept can be promoted, accepted and utilised by the team. I believe this may encourage team members to get to know and understand each other from a personal as well as a professional perspective. Perhaps this concept will become a prerequisite for effective teamwork, along with ongoing support and delegation of skills and tasks effectively to the most appropriate team member. This will be in addition to understanding the unique personal attributes each team member offers to the team. This may highlight their strengths and weaknesses, opportunities and threats. In essence, this approach may enhance the process of achieving high performing teams for goal setting performance; personal and professional fulfillment.

I have put forward the notion that one essential ingredient for team performance is to value each and every team member's contribution, at the same time utilising the most appropriate team member with the necessary skills/attributes for any given task. Roles and functions that complement each other are in line with the principles of teamwork, benefiting both patients and General Practice. More attention should, perhaps, be placed on quality of care rather than defining the discipline specific roles that have traditionally been aligned with each task.

On reflecting on the focus group data, I have tried to incorporate my thoughts on the essential ingredients of teams (Katzenbach & Smith 1992) into a model (refer to Fig 8). This model is included as a starting point for further discussion and to assist effective team and teamwork for the General Practice setting. The model draws upon Maslow's (1954) hierarchy of needs for self-actualisation. Maslow proposes that there are five components required before an individual can reach self-actualisation. These five components have been ranked from the lowest to highest; the lowest being the basic human physiological needs (oxygen, water, and food) and safety needs (shelter and sense of security). These components must be met before the higher needs can be established. The higher components are classified by Boyle and Wilson, cited in Murray and Zentner (1997) and commence with personal growth (the need for love and belonging). The highest components are esteem from others (feelings of self-respect respect from others, sense of achievement). Self-actualisation can only be achieved when all of the lower components have been met.

According to Maslow the overall aim of self- actualisation is to become a better and more fulfilled person. This requires motivation and direction. To motivate people to self-actualisation, "there must be freedom to speak, to pursue creative potential and to inquire; an atmosphere of justice, honesty, fairness and order; and environmental stimulation and challenge" (Boyle & Wilson, cited in Murray & Zentner 1997:235). I believe Maslow's model offers insight into the barriers and requirements for effective teamwork. Likewise I propose a team can also reach self-actualisation as demonstrated in its performance. Like Maslow's model I have identified five essential components, which also builds from the lowest to the highest. The lowest components include setting goals and identifying roles.

The higher components include; attending to individual team members' persona and personal attributes, teamwork and high performance (self-actualisation of the team). If these components work in an ordered and well thought through plan, there is the potential for team success. This teamwork model is in an early conceptual form and requires further work and ongoing research in the General Practice environment. I have included it as a final summary to reinforce the complexity I believe surrounds the concept and working strategies for the effective delivery of teamwork and teams in the General Practice setting in New Zealand.

6.5.1 *Proposed Model for General Practice Effective Team & Teamwork*

High Performing Teams

Teamwork

Persona

Needs met & personality bloom

Role/skills

Understanding & acceptance

Goals

Identifying & agreeing on problem/solution
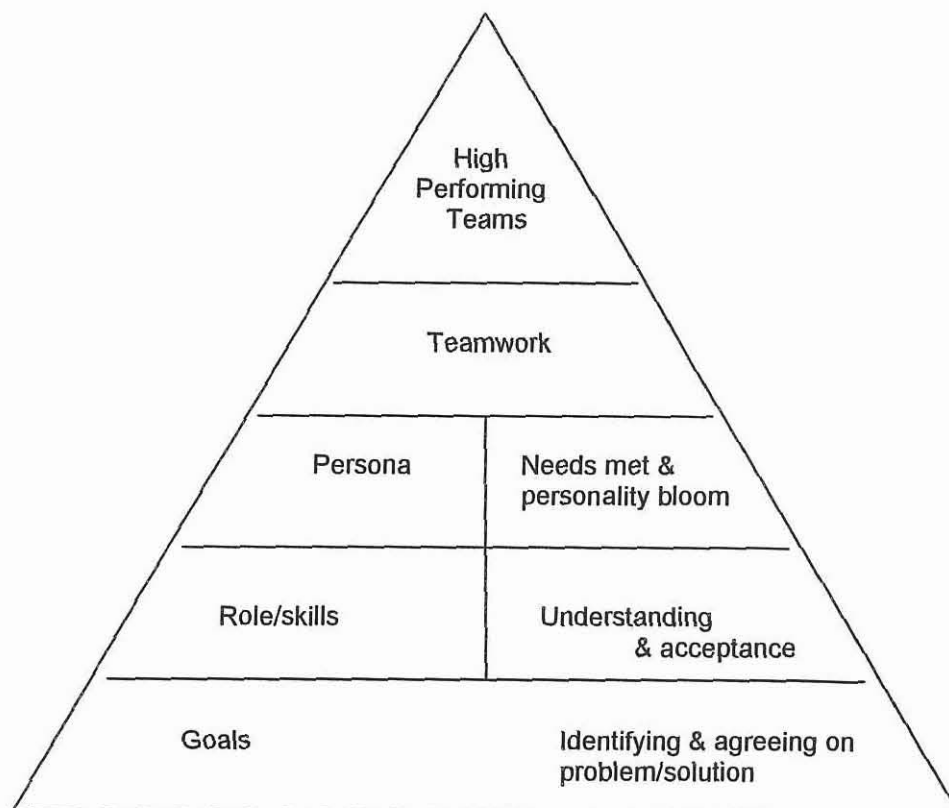
Fig. 8 - Proposed Model for General Practice Effective Team & Teamwork

(using Maslow's five stage hierarchy of needs)

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6.6   Further Work

I plan to continue to work on this model and see if it is useful in assisting teams to become more effective. I have presented the ongoing findings of this research in two stages. The presentations were displayed as two separate posters. The first set of findings were presented in a poster format in 1999 at the 8th International Nurse Practitioner Conference in Cardiff, Wales (Appendix 11). The second stage of the research was presented as a poster at the WONCA Asia Pacific Regional Conference held in Christchurch 2000 (Appendix 12). Furthermore, additional work is necessary on the five components I have put forward as essential elements for teamwork and teams. In particular, I am interested in trying to define the importance of individual team members' personality attributes and how these affect role. I intend to commence a study with this in mind. This study has been funded by the HFA, and will be run through the National Centre of Rural Health. The aim of this study is to describe the dimensions of team effectiveness as it applies to rural health service teams. The proposed model that develops from this research will be tested within this study. It is anticipated that the data will be used to improve rural health service delivery by developing a structured programme which rural health service teams can use to foster effective successful teams. In this way ongoing interest in teams and teamwork will extend the contribution this thesis makes to guiding effective primary health care teams.

Appendix 1

Confidentiality agreement between researcher and assistant/ transcriber

Statement of Confidentiality

Re: **Transcribing tape recording dialogue from focus group meetings from research on primary health care teamwork**

I _____

herby agree not to divulge to any third party any information relating to participants or the dialogue content from the above research tape recordings or printed material which I have access to. I understand that the tape recordings which I have transcribed have had all participants names substituted by random names or letters of the alphabet.

Signature of Transcriber.. Date............................

Full Name ....

Signature of Researcher.. Date............................

Full Name ....

Project explained by...

Date...

(Note: copy to be retained by transcriber)

Appendix 2

Letter issuing provisional ethical approval

CANTERBURY ETHICS COMMITTEE

23 November 1998

Jean Ross
Department of Public Health and General Practice
Christchurch School of Medicine
P O Box 4345
CHRISTCHURCH

Dear Jean Ross

The core Primary Health Care Team's understanding of current and future roles, individual and collective, with the prospect of an expanded primary health care service in general practice
Investigator: Jean Ross   Supervisors: Alison Dixon, Leslie J Toop
Protocol Number: 98/11/119

Thank you for the above application which was considered by the Committee at its meeting on 16 November and provisionally approved. Approval will be finalised once the following points have been addressed.

The third aim could be more clearly stated eg "To enable (or facilitate) general practitioners and practice nurses to gain a new understanding of each others' roles within an expanded primary health care service in general practice".

How will the researcher account for people in the same practice or people in different practices? How will the individual participants be protected if there are more than one from a practice?
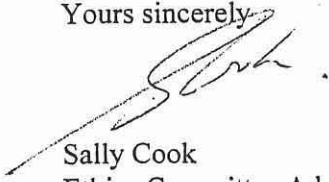
Clarification is requested of what information from the focus group is available to the participants for editing. Will the whole transcript be available for focus group participants to edit their own comments or will themes be discussed before the next meeting?

The Committee wondered whether having a "series" of information sheets was the best way of providing information. As the participants are health professionals, it is suggested that "you may wish to contact the Health and Disability Consumer Advocate" is changed to "you may wish to contact your professional organisation."

Suggested amendments to the letters/information sheet and consent form are indicated on the attached copies.

I look forward to your response to the above points which will be reviewed by a Committee member prior to final approval by the Chairperson under delegated authority. If you have any queries, please contact me on 372 1017.

Yours sincerely

Sally Cook
Ethics Committee Administrator

enc

North Mana Hauora A Rohe O Te Raki   **Midland**   **Central** Te Ihonga Hauora   **South** Ko te mana Hauora, Ku te mana Takata

Appendix 3

Letter to ethics committee including adjusted alterations

CHRISTCHURCH SCHOOL OF MEDICINE

Te Kura Rata o Ōtautahi

Department of Public Health and General Practice

1 December 1998

Sally Cook
Canterbury Ethics Committee
PO Box 3877
CHRISTCHURCH

Dear Sally

The core primary health care team's understanding of current and future roles, individual and collective, with the prospect of an expanded primary health care service in general practice.

Investigator:	*Jean Ross*
Supervisors:	*Alison Dixon, Leslie J Toop*
Protocol No:	*98/11/119*

Thank you for your letter of 23 November 1998 informing me about the above application which has been given provisional approval by the Ethical Committee.

I note the Committee's request for further clarification in the following areas which are numbered as in the Ethical Proposal:

The third aim now reads:

(1.2) * "To enable practice nurses and general practitioners to gain a new understanding of each other's roles within an expanded primary health care service in general practice."

(4.2) * I (the researcher) will account for participants in the same practice or in different practices by, inviting potential participants to provide their profession and work location on the reply slip when they indicate their interest in participating in this research.

* Potential participants, will receive a further letter on receipt of the reply slip (indicating their interest in participating in this research) indicating this research, is open to all practice nurses and general practitioners of the Canterbury region, and it just may happen that a working colleague from the same practice may be a participant of the focus group. If by chance two or more colleagues from the same work place volunteer one only will be conviently selected by the researcher (this has been added to the exclusion criteria 3.4).

Measures

Measures have been put in place in the research design to protect all participants by:

* Agreeing on the core ground rules for focus group meetings and signing the consent form.

* Developing group ground rules which can be included with the core ground rules for the focus group meetings.

* Facilitation of the focus groups will ensure all participants have an equal opportunity to contribute within the group discussions.

* Participants will be able to withdraw from the research at any time.

(4.1, 5.2) * The discussion generated from the focus group meetings will be audiotaped and fully transcribed by a professional transcriber. The researcher will listen to the tapes to validate the transcription and draw out themes. The <u>themes</u> will be sent to the participants for their validation. This process will contribute to the credibility of the dialogue by the participants. The analysis of the data, forms a continual process throughout the research together with the themes and dialogue generated by the focus group meeting. Confidentiality and anonymity will be maintained by the use of pseudonyms against participants quotes, this will protect participants of both focuis groups.

* A series of information sheets will be offered to each potential participant, following the initial meeting with myself to clarify the research process prior to the signing of the consent form. The information sheets will provide further explanation in the written form which the potential participants can read and discuss further with the researcher if necessary. The information sheets will read "You may wish to contact your professional organisation."

If there are any futher queries I am contactable by telephpne on (03) 3640410.

Yours sincerely

Jean Ross
Lecturer Primary Rural Health Care
Rural Nurse Coordinator, Southern Region

Appendix 4

Letter confirming ethical approval

CANTERBURY ETHICS COMMITTEE

South Office
4th Floor, 144 Kilmore Street
PO Box 3877
CHRISTCHURCH
New Zealand
Telephone 03 372 1000
Facsimile   03 372 1015

17 December 1998

Jean Ross
Department of Public Health and General Practice
Christchurch School of Medicine
P O Box 4345
CHRISTCHURCH

Dear Jean Ross

The core Primary Health Care Team's understanding of current and future roles, individual and collective, with the prospect of an expanded primary health care service in general practice
Investigator: Jean Ross   Supervisors: Alison Dixon, Leslie J Toop
Protocol Number: 98/11/119

Thank you for your response to the Committee's concerns. I am pleased to advise that, using the delegated authority granted her by the Committee, the Chairperson of the Canterbury Ethics Committee has given final ethical approval for this study to proceed in Canterbury.

Approvals granted to protocols are for 12 months. If, after 12 months the study is not completed, it will be necessary to forward to the Committee a request for an extension. A form to assist with this is available from the Administrator. Please quote the above protocol number in all correspondence relating to this study.

It is also a requirement of the Committee that researchers submit a report upon completion of their studies. I look forward to receiving your report in due course.

· Yours sincerely

Sally Cook
Ethics Committee Administrator

North
Mana Hauora A Rohe O Te Raki

Midland

Central
Te Ihonga Hauora

South
Ko te mana Hauora, Ko te mana Takata

Appendix 5

Letters of invitation to potential participants

CHRISTCHURCH SCHOOL OF MEDICINE
Te Kura Rata o Ōtautahi
Department of Public Health and General Practice

22 January 1999

Dear Colleague

Participating in a Research Study of Teamwork in Primary Health Care

My name is Jean Ross I am currently undertaking a research study as part of my Master of Arts (Nursing) at Victoria University, under the supervision of Professor Alison Dixon (Victoria University) and Professor Les Toop from the Department Public Health & General Practice, Christchurch. I have a position as Lecturer in Primary Rural Health Care within this department.

Both national and international literature suggests that practice nurses and general practitioners working collaboratively can provide more efficient and effective primary health care. Teamwork seems to be the key and a mutual understanding of each others roles a prerequisite to establishing full partnership.

This study aims to both explore and advance practice nurses' and general practitioners' understanding of traditional roles. New understandings which may emerge could lead to the development of more effective teamwork.

I would value your contribution in this research. The research will be based around a series of focus group meetings. The focus groups will comprise three groups; one of practice nurses, one of general practitioners, and the other including members of both groups. The participants will currently work in primary health care within Canterbury. To participate you will be required to volunteer your time which is anticipated to be a total of six and a half hours. This will include a preliminary meeting to discuss the research, answer any queries and gain consent from you to participate. The remaining time will be divided into four facilitated focus group meetings; two discipline specific, the remaining two will amalgamate both groups. The focus group meetings will commence February 1999 and be held approximately six weeks apart. If by chance two or more colleagues from the same work place volunteer one only will be convienently selected by the researcher.

PO Box 4345, Christchurch, New Zealand Email *publichealth@chmeds.ac.nz*

Public Health	General Practice
Tel 64 3 364 0450 Fax 64 3 364 0425	Tel 64 3 364 0891 Fax 64 3 364 0269

If you are interested in participating, please complete and send back to me the enclosed reply slip in the prepaid addressed envelope. I will then contact you by telephone to arrange a meeting to discuss the research, and your possible contribution, in more depth.

If you have any further questions about this study please contact me, or my supervisors:

Professor Alison Dixon	04 471 5363
Professor Les Toop	03 364 0891

Thank you for considering participating in this study.

Yours sincerely

Jean Ross B.N., RGON., ONC.
Lecturer Primary Rural Health Care

CHRISTCHURCH SCHOOL OF MEDICINE

Te Kura Rata o Ōtautahi

Department of Public Health and General Practice

Jean Ross
Department of Public Health & General Practice
Christchurch School of Medicine
PO Box 4345
CHRISTCHURCH

Dear Jean

Re: Participating in a Research Study of Primary Health Care Teamwork

I am interested in participating in the above study. I wish to meet with you to discuss this research in more depth.

Name.:.. Profession......................................

General Practice Address...

....

Phone.. Best time to call................................

Signed...

Date...

<div style="border:1px solid black; text-align:center;">

Please return this form in the enclosed prepaid addressed envelope

</div>

Dear

Re: Participating in a Research Study of Primary Health Care Teamwork

Thank you very much for completing and returning the response letter indicating your interest in participating in the above research. I will be in contact with you by telephone within the next seven days to arrange a face to face meeting to discuss the research, your contribution and to answer any questions you may have.

In the meantime I enclose further details about the research.

The specific aims of this study are:

- to explore practice nurses' and general practitioners' understanding of their current roles,
- to explore practice nurses' and general practitioners' understanding of each others' current roles,
- to enable practice nurses and general practitioners to gain a new understanding of each others' roles within an expanded primary health care service in general practice.

To undertake this research it will be necessary to engage with practice nurses and general practitioners who currently work in primary care within Canterbury. Your position as a primary health care practitioner will assist, to explore and discuss core primary health care teams understanding of current and future roles in light of an expanded primary health care service in general practice. Participation in this study is voluntary and you may withdraw at any time, without giving a reason. Withdrawing will in no way affect your future professional relationship with this department.

As indicated in the previous letter your participation in this research will require you to volunteer your time which is anticipated to be a total of six and a half hours. This will include a preliminary meeting to discuss the research, answer any queries and gain consent from you. The remaining hours will be divided into four focus groups. The focus groups will comprise two discipline specific, and two amalgamated groups. The focus groups will meet for an hour and a half on four separate occasions. The focus groups will commence February 1999 and be held six weeks apart. An allowance is available for travel to and from the focus group venue.

Successful focus group function is dependent upon a number of factors. To minimise problems core written ground rules will be available at the time of signing consent. In addition participants of the focus groups will further contribute to the formation of the core ground rules at the commencement of the first focus group meeting.

The intention of the focus group meetings is to generate information in order to gain a deeper insight on the research topic. Insights will be generated through discussion within the focus group meetings.

The discussion from the focus group meetings will be audiotaped. The tape recordings will be transcribed. Analysis of the transcripts will provide themes which will be referred back to focus group participants for validation. The themes will form a basis for discussion at the subsequent focus group meeting. All discussions will be treated in the strictest confidence by the researcher. In reporting this research, no individual participant will be identified. Names of participants will not be associated with either written or taped records. All of the information will be kept securely throughout the duration of the study, and for the following five years. All information will then be destroyed by myself.

A summary of this research will be provided to you and made available to other interested parties, in addition to being published in relevant journals.

This research has received ethical approval from the Canterbury Ethics Committee. If you have any queries or concerns about your rights as a participant in this study you may wish to contact your professional organisation. Your contribution in this research may be the forerunner of further research which you may be invited to participate at a later date.

If you have any further questions, please contact me on 03 364 0410, or my supervisors:

Professor Alison Dixon	04 471 5363
Professor Les Toop	03 364 0891

Thank you for considering participation in this research. I look forward to meeting you in the near future.

Yours sincerely

Jean Ross B.N., RGON., ONC.
Lecturer Primary Rural Health Care

Appendix 6

Full explanation of study and research design

Research Information Sheet

Title: Participating in a Research Study of Primary Health Care Teamwork

Principal Investigator: ....

Full Name: ....

Position: ....

Address: ....

....

Telephone: ....

Supervisors: Professor Alison Dixon (04) 471 5363

Professor Les Toop (03) 364 0891

Date Compiled: ....

Research Information Sheet

Re: Participating in a Research Study of Teamwork in Primary Health Care

Potential Participants' Plan

- Participants will be selected through a sample of convenience.

- A letter will be sent inviting potential participants to be involved in the research, including a reply slip to be sent back to the researcher.

- On receipt of the reply slip the researcher will telephone the potential participant to arrange a convenient face to face meeting.

- Prior to the meeting the researcher will send a further letter with additional information regarding the research.

- The meeting will discuss the research, study design and focus group format, participants contribution, time frame, the benefits for the participants, and the core ground rules will be discussed.

- It will be explained to the participant that s/he may withdraw from the research at any time.

- Participants will be encouraged to ask questions and have their queries answered.

- Information will be given with regard to the necessity of signing a research consent form, indicating individual participants understanding about the research, the core focus group ground rules, and the participants contribution.

- Participants at the end of the meeting will be given a research information sheet describing the research and study design. Participants will be encouraged to contact the researcher for further information if necessary.

- The researcher will contact the potential participant seven days following this meeting, asking the potential participant if s/he would like to contribute to this research.

- A further meeting will be required to sign the research consent for participants who agree to contribute

- A letter of thanks will be sent to all potential participants.

THE STUDY DESIGN

Re: Participating in a Research Study of Primary Health Care Teamwork

- This study aims to generate discussion on the research topic through four facilitated focus group meetings.

- Two discipline specific focus groups will be formed and one amalgamated group.

- One group will consist of between four and six practice nurses and the other, between four and six general practitioners. The amalgamated group will consist of all members from the individual groups.

- The focus groups will meet on four separate occasions; two discipline specific and two amalgamated groups. Each meeting will last approx one and a half hours each. The meetings will commence in February 1999 and be held six weeks apart.

- Focus group meetings will be held at a neutral venue which is convenient to all participants. Travel allowance and refreshments will be available.

- On the first occasion the group will be invited to discuss, agree and build on the core ground rules provided by the facilitator before moving onto the topic of discussion.

- Subsequent focus group meetings the written ground rules will be displayed at the focus group meeting.

- The role of the facilitator will be to keep the participants focused, probe deeper into the topic, encourage conversation and ensure, at all times, the group's ground rules are followed.

- The facilitator will be myself (the researcher). As facilitator I will intervene only to refocus the discussion, to invite participants to speak, to restart the discussion should the conversation stop or to clarify any issues and to scribe focus group brainstorming sessions on a flip chart.

- As facilitator I will ensure all participants have an equal opportunity to contribute within the group discussion.

- Information will be gathered by generating discussions using a series of open ended questions facilitated by the facilitator to encourage participants to explore the topic.

- The focus group meeting discussions will be tape recorded and later, fully transcribed by a professional transcriber.

- Ideas produced by brainstorming will be written on a flip chart and retained by the facilitator for analysis.

- The researcher will listen to the tape recordings to validate the transcription and draw out themes.

- The themes will be sent to the participants for their validation two weeks prior to the subsequent focus group meeting.

- The themes will be used to generate future discussions at subsequent focus group meetings.

- Transcribed focus group meeting discussions and flip chart information on the topic may generate participants' own questions which can then be further explored by subsequent focus group meetings.

- The analysis of the data will be a continual process throughout the study together with the themes and dialogue generated by the focus group meetings.

- A descriptive account of all the themes, ideas and conclusions will assist an overall critical analysis of the information on the topic.

- Access to the raw data will only be available to the researcher, the researcher's supervisors and the professional transcriber.

- All transcriptions, tape recordings and paper data will be stored in a separate locked cabinet throughout the study and for the following five years. The raw data will then be destroyed, the paper data shredded and the audio tapes erased. The computer will be password protected.

- Confidentiality and anonymity will be maintained by the use of pseudonyms and checking with the participants prior to any public viewing of results.

The Research Analysis

- The research analysis will be discussed with the participants prior to the discussion dialogue being written up.

- The research analysis will be available in an unpublished report. Each participant will receive a copy.

- The research analysis will be made available to any funding bodies who have provided financial assistance for the research.

- The research analysis will be submitted to a range of relevant peer review journals.

- The research analysis will be disseminated at local, national and international conferences including local seminars inviting core primary health care team members.

- The confidentiality and anonymity will be maintained by the use of pseudonyms and checking with the participants prior to any public viewing of results.

- For publication purposes, all identified dialogue from the discussions will be removed.

Focus Group Meetings

- Focus group meetings will be held at a neutral venue convenient for the participants. This will be dependant on the participants who engage in the study.

- Travel allowance to and from the focus group meeting venue will be provided to participants.

- Refreshments will be provided to participants free of charge at all focus group meetings.

- On the first occasion the group will be invited to build on the core ground rules provided by the facilitator including confidentiality of discussions.

- The facilitator's role will be to keep the participants focused, probe deeper into the topic, encourage conversation and ensure, at all times, the group's ground rules are adhered to.

- The facilitator will be myself (the researcher). As facilitator I will intervene only to refocus the discussion, to invite participants to speak, to restart the discussion should the conversation stop or to clarify any issues and to transcribe focus group brainstorming sessions on a flip chart.

- As facilitator I will ensure all participants have an equal opportunity to contribute within the group discussion.

- Each focus group meeting will commence with an introduction from the participants, recapping of group ground rules, summarising study topic themes from previous focus group meetings, opening the meeting up for ongoing discussion on the topic.

- Information will be gathered by generating discussions using a series of open ended questions facilitated by the facilitator to encourage participants to explore the topic.

- The focus group meeting discussions will be tape recorded and later, fully transcribed by a professional transcriber.

- Brainstorming of participants ideas on the topic will be written on a flip chart and retained by the facilitator for analysis.

- After approximately one and a quarter hours, participants will be asked by the facilitator to summarise their own view points.

- If issues relating to ethnicity become evident during focus group meetings, appropriate expertise will be sought for guidance and direction.

Facilitator's Responsibility in Running the Focus Group Meeting for the Research Study

- Focus group meetings need to be well facilitated, run to time and stay within group ground rules.

- The facilitator will invite participants to the first focus group meeting. For subsequent meetings the facilitator will remind participants of the venue date and time. Information which is shared within the group needs to be kept confidential otherwise there could be serious invasion of privacy. It is therefore important the focus group ground rules are adhered to by the group. Ground rules will emphasis that each participants opinion and contribution is important. One participant to talk at a time, and participants to be encouraged to talk to the group and not the facilitator.

- The facilitator will prepare the venue, ensuring it is comfortable, and relaxing within a safe environment which is conducive for participants to discuss their individual opinions on the topic. The facilitator will be responsible for the functioning of all recording equipment used during the focus group meeting. Travel allowance and refreshments will be provided for the participants by the facilitator.

- The facilitator will open and close the focus group meeting, thanking participants for their contribution to the discussion, and their time. The facilitator will explain the aim of the study and encourage all participants to talk to each other. Broad open ended questions will be used as required by the facilitator to keep the discussion relevant to the topics under study.

- If disagreements within the focus group meeting arise, they may be used to encourage participants to elucidate their point of view and to clarify what they think. These differences of opinion can be discussed within the group. This assists in exploring the topic further.

- The facilitator will be responsible for the analysis of all of the tape recorded material and written information, drawing out themes, and sending this information to the participants prior to subsequent focus group meetings. All paper data, tape recordings and transcripts will be securely locked by the facilitator.

- At the close of the research information will be given on how they can obtain the research analysis.

Focus Groups

A focus group meeting consists of a small group of individuals with a common characteristic that will allow a free exchange of views. Focus groups are the means of obtaining discussion on a topic. They have the advantage of being used in poorly understood areas. They allow for greater flow of information among participants than other methods of data collection. The group generates themes on a topic which can be explored then in more depth. Focus groups are useful for exploring people's knowledge and experiences and can be used to examine not only what people think but how they think and why they think that way. Focus groups are used to listen and learn. They are not to teach, or inform, but to gain a deeper understanding on the topic being studied. Participants' attitudes, values and perceptions of a particular topic or problem are welcomed in a permissive, non threatening environment. There should be no fear of criticism from other participants and for this reason core ground rules became part of the focus group. Participants are encouraged to talk to one another, asking questions, exchanging anecdotes and commenting on each other's experiences and points of view.

Focus group discussions will be guided by a facilitator. It is appropriate to guide the study with a series of open ended questions. In the course of a discussion the opinion of a participant may alter. This raising of awareness is consistent with the philosophical basis of the study which has been informed by critical theory.

Appendix 7

Focus group core ground rules

Core Written Ground Rules for Focus Group Meetings

Re: Participating in a Research Study of Primary Health Care Teamwork

It is necessary each member of the focus groups agree to the core ground rules. This will ensure the smooth running and safety for all focus group participants.

Additional ground rules can be added by focus group members, with discussion and consensus.

- All participants contributions are valid.

- There are no right or wrong answers, each participants contribution is valid.

- All participants to be encouraged by the group to contribute to dialogue.

- Only one person to speak at a time.

- No side conversations amongst other group members whilst one person is speaking.

- Introduce oneself when speaking, for tape recording purposes.

- Confidentiality and anonymity of focus group members and dialogue not to be discussed with any third party, all discussions to remain within the room.

- Meeting to start and finish on time.

misc\study design

PO Box 4345, Christchurch, New Zealand Email *publichealth@chmeds.ac.nz*
Public Health   General Practice
Tel 64 3 364 0450 Fax 64 3 364 0425   Tel 64 3 364 0891 Fax 64 3 364 0269

Appendix 8

Research consent form

CHRISTCHURCH SCHOOL OF MEDICINE
Te Kura Rata o Ōtautahi
Department of Public Health and General Practice

Consent Form *(2 pages)*

Re: Participating in a Research Study of Primary Health Care Teamwork

I _____

have read and understood the research information sheet dated _____ for

participants taking part in the study designed to generate information to gain a deeper insight

on teamwork in primary health care.

- I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.

- I understand that taking part in this study is voluntary and that I may withdraw from this study at any time and this will in no way affect my collegial relationships.

- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

- I understand I will receive a signed copy of this consent form.

- I understand the researcher's supervisors, Professor Alison Dixon and Professor Les Toop, may have access to confidential information from the research.

I have had time to consider whether to take part	Yes ☐	No ☐
I know whom to contact if necessary for further information	Yes ☐	No ☐
I have read and agree to adhere to the core written ground rules	Yes ☐	No ☐
I consent to the focus group discussion being audio-taped	Yes ☐	No ☐
I wish to receive a copy of the results	Yes ☐	No ☐

I understand the tape recorded discussions will be transcribed by a professional transcriber,
who has signed a Statement of Confidentiality.

I (full name) _____

herby consent to take part in this study.

Signature of Participant.......................................   Date.............................

Signature of Researcher...................................   Date........................

Full Name..

Contact Phone Number for researchers:

        Professor Alison Dixon   04 471 5363
        Professor Les Toop   03 364 0891
        Jean Ross   03 364 0451

Project explained by...

Signature...   Date...........................

Appendix 9

Questionnaire seeking demographic details of participants

Personal details of Participants in a Research Study

1. What is/are your job title/s?...
    ....

2. How many tenths per week do you work in the above position/s?...........................
    ....

3. Do you work in a rural or urban practice?   ....

4. Are you a female or male practitioner?   ....

5. Do you have any other jobs?   (Please describe)   *Yes* ☐   *No* ☐
    ....

6. Do you work simultaneously with other health professionals?   *Yes* ☐   *No* ☐

    If you answered "yes" to question 5, please answer question 6.   If you answered "no" to question 5, move on to question 7.

7. Who do you work with?   General Practitioners   *How many*... ... ...
                                   Practice Nurses   *How many*... ... ...

8. How long have you been working in your current position/s?   .... *years* .... *months*
                                                                   .... *years* .... *months*

9. How long have you been working as a general practitioner?   .... *years* .... *months*

10. What are your qualifications?
    Qualification... *Year obtained*.................
    Qualification... *Year obtained*.................
    Qualification... *Year obtained*.................

Appendix 10

Definitions of Teamwork

TEAMWORK

The literature on teamwork indicates for teams to be effective there are a number of required essential elements. This research has taken one element and focused on the understanding practice nurses and general practitioners have of their own, and each others' role, through discussions held at a number of focus group meetings.

I have become confused and believe the literature is misleading. The literature states for effective teamwork there are a number of essential elements required. One element indicates the necessity of team members understanding each others' **function or role,** as described in the following descriptions highlighted in bold. Please note the different emphasis placed on the requirements for each member of a team to understand their own and each other's **function** and/or **role.**

Defining Teamwork

Gilmore, Bruce and Hunt (1974) describe the essential elements of teamwork as:

- The members of the team share a common purpose which binds them together and guides their actions.
- **Each member of the team has a clear understanding of their own functions, appreciate and understand the contributions of other health professionals and recognises common interests.**
- The team work by pooling knowledge, skills and resources and all members share responsibility for outcomes.
- The effectiveness of the team is related to its capacity to carry its work and its ability to manage itself as an independent group of people.

Poulton & West (1993, p.918) state a definition of the primary health care team, adopted by the Harding Committee (1981) as:

> **"An independent group.....who shares a common purpose and responsibility, each member clearly understanding his/her function and those of other members so that all pool skills and knowledge to provide an effective primary health care service."** (Dept of Social Security 1981)

The Harding Report described a team as:

> "A primary health care team is an independent group of general medical practitioners and secretaries and/or receptionists, health visitors, district nurses and midwives who share a common purpose and responsibility, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide an effective primary health care service."

A number of authors define what is meant by "teams" and "teamwork". The concept of the "team" has a number of essential elements who:

- share a common purpose and common goals as described by Hayes (1997),
- **have a clear understanding of each others' roles and abilities implies Thomas & Corney (1993),**
- regularly interaction with each other, usually through informal or formal team meetings state West & Slater (1996).

Colt (1997 p.851) describes:

- **That team members have a shared understanding of roles, norms and values within the team.**
- The team functions in an egalitarian, cooperative, interdependent manner.
- The combined effects of shared, cooperative decision making are of greater benefit to the patient than the individual effects of the disciplines on their own.

Pritchard and Pritchard (1994) state **"each team member must have a clear perception of their own and must be aware of each other's role. Many professional roles are changing, resulting in role-uncertainty and lack of confidence". (p.46)**

Definition of Role

There are many definitions of role. Gilmore, Bruce & Hunt (1976) imply, "a role constitutes the behaviour expected of individuals by virtue of their occupying a particular position in an organisation.

Professional role expectations are learned through the educational and socialisation of a specific profession. The identified values of that profession represent its image. Identifying with the values of a particular profession provides an individual or group with the attributes recognised to be part of that particular profession. It also guides them on what not accepted behaviour. Health professionals identify with the role which is typically associated with the range of duties and responsibilities of their profession (Scott 1995).

Different professionals have identified roles and functions which may at times overlap. It is not unusual for health professionals to work within their own specific professional role (Duncanis and Gaudin 1979). Think back to this morning's session on disciplines. Is there any resemblance between the professional role and discipline?

Q.   *What do you perceive as the attributes that make up the general practitioner's role(s)?*

Q.   *Are these perceptions appropriate and consistent with teamwork?*

Q.   *What do you perceive as the attributes that make up the nurse's role(s)?*

Q. · *Are these perceptions appropriate and consistent with teamwork?*

Q.   *In your view, do either or both the nurse's or general practitioner's role need to change to accommodate what you have discussed?*

It has been argued that many doctors seem to see nurses as helpers and extenders (Tomkin-Greener 1985, cited in Colt 1998) and encourage a form of teamwork in which nurses remain subordinate (Campbell-Heider & Pollock 1987, cited in Colt). Whereas it is argued many nurses see teamwork as providing greater access to patient care (Tomkin-Greener, cited in Colt) and seek a form of teamwork which encourages mutual collegiality with the doctor (Campbell-Heider * Pollock 1987, cited in Colt).

Appendix 11

Role Identification for Effective General Practice

Teamwork- Poster Display

Role Identification for Effective General Practice Teamwork

Research Question

The intention of this research was to explore in greater depth the reality of teamwork in general practice. If the public is to receive an expanded health care service it will be essential for practice nurses and general practitioners to work as an effective team. To assist teamwork, it will be necessary for practice nurses and general practitioners to understand each other's current and future roles, to make best use of their available expertise.

The Specific Aims of the Project

1. To explore practice nurses' and general practitioners' understanding of their current roles.

2. To explore the practice nurses' and general practitioners' understanding of each other's roles.

3. To enable practice nurses and general practitioners to gain new understandings of each other's roles within an expanded primary health care service in general practice.

Focus Groups

A focus group meeting consists of a small group of individuals with a common characteristic that will allow a free exchange of views. Focus groups are the means of obtaining discussion on a topic. The group generates themes on a topic which can be then explored in more depth. Participants are encouraged to talk to one another, asking questions, exchanging anecdotes and commenting on each other's experiences and points of view.

GENERAL PRACTICE

General practice provides quality, comprehensive and continuing health care to individuals, their families, whanau and communities. The essence of general practice is continuity of care for people through generations.

Practice Nurses

Practice nurses are employed by general practitioners through a government part subsidy. They have an evolving and varied role and the range of services vary depending on the community.

However the range of services varies from simple task performance to an autonomous role, providing independent appointments which allow or enable practice nurses to work collaboratively with the general practitioner.

"Role of caring while undertaking a number of acute, chronic and preventative health care."

General Practitioners

The majority of general practitioners are self employed and employ a number of staff.

The general practitioner generates income through part government payments for health services and part payment by patients.

"Role includes clinical generalists and independent practitioners within a framework of structured fee for service which may cause terrific push and pull."

FUNDING

General practice is funded a number of ways; General Medical Services (GMS), Accident Compensation Corporation (ACC), insurance companies, obstetrics schemes and the patient themselves. In some cases Independent Practising Associations (IPAs) subsidise certain services. Population based funding (capitation) is another means of funding.
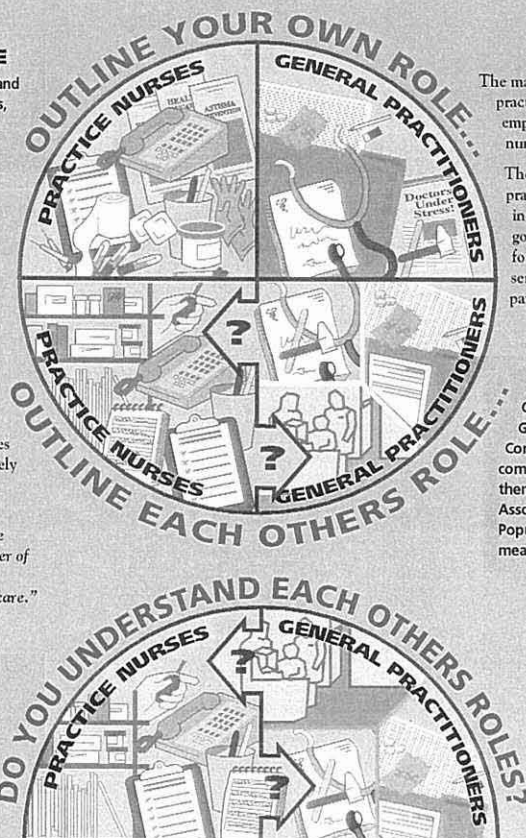
CRITICAL THEORY

Critical theory is a social research method assisting practitioners to search below the surface, make visible the invisible and expose their traditional roles as practitioners which they may take for granted. By questioning their previous assumptions of their clinical role, practitioners may be in a more informed position to analyse the gaps, silences and ambiguities which act as barriers to full team collaboration.

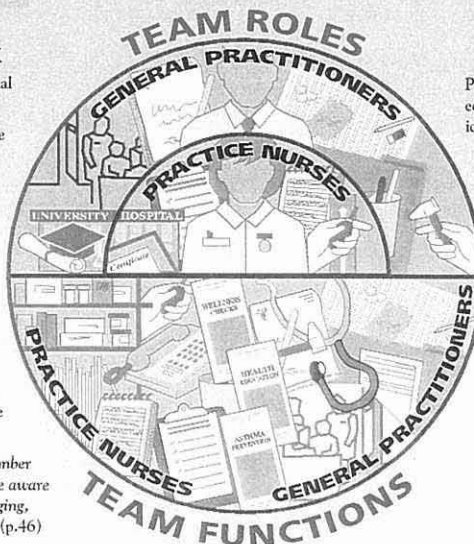ANSWER: YES

DEFINING TEAMWORK

Gilmore, Bruce and Hunt (1974) describe the essential elements of teamwork as:

- *The members of the team share a common purpose which binds them together and guides their actions.*

- *Each member of the team has a clear understanding of their own functions, appreciate and understand the contributions of other health professionals and recognises common interests.*

- *The team work by pooling knowledge, skills and resources and all members share responsibility for outcomes.*

- *The effectiveness of the team is related to its capacity to carry its work and its ability to manage itself as an independent group of people.*

Pritchard and Pritchard (1994) state, *"each team member must have a clear perception of their own and must be aware of each other's role. Many professional roles are changing, resulting in role-uncertainty and lack of confidence".* (p.46)

DEFINING ROLE

Professional role expectations are learned through the educational and socialisation of a specific profession. The identified values of that profession represent its image. Identifying with the values of a particular profession provides an individual or group with the attributes recognised to be part of that particular profession. It also guides them on what is not accepted behaviour. Health professionals identify with the role which is typically associated with the range of duties and responsibilities of their profession (Scott 1995). Different professionals have identified roles and functions which may at times overlap.

Appendix 12

Re-defining Role for Effective General Practice

Teamwork- Poster Display

Re-defining Role for Effective General Practice Teamwork

Framework	Method	Process
false consciousness	- raise consciousness	- barrier to teamwork, role identification
enlightenment	- focus group discussion	- role
emancipation	- new found understandings	- alter social arrangements
empowerment	- action	- alleviate crisis

FALSE CONSCIOUSNESS

TRADITION

GENERAL PRACTITIONERS

FUNDING — UNIVERSITY — EMPLOYMENT

PRACTICE NURSES

Perceptions of Reality

It is not uncommon for health professionals to work within an oppressed context and to suffer because of the situation (Fay 1987). People's interpretation of their world can be distorted by underlying socio-political forces which constrain their action.

When people's situation or circumstances are exposed through critique their consciousness may be raised. People accept their circumstances or situation as real and are powerless. People don't realise life could be different and they do have the power to change their lives and not to accept their circumstances

Enlightenment

Enlightenment is a process of self reflection (Fay 1987); seeing one's own context or situation in a different light while interpreting a situation (context) in a new way. It is then possible to compare the new way in light of the old.

Emancipation

Emancipation is a process of liberation (Fay 1987). This means a consciousness of becoming aware of one's self within the socio-political context one works within.

This knowledge of one's context allows people the ability to seek below the surface and uncover the myths and illusions (false consciousness) and expose the real truths and present these as a newfound reality.

Attributes

This research identified that role was comprised of two elements; professional and personal attributes. Personal attributes are hidden components of members of the team. Attributes can enhance team goals and performance and individual performance.

It can be stated that roles are therefore not just about rights and obligations but also include the attributes individuals offer as part of the role and function.

If practitioners' attributes are not valued within the team, tension may arise between the personal elements and the professional roles. Team members may then look to other areas of their life for their personal needs and satisfaction to be met. This could have unsatisfactory results for the performance of the team.
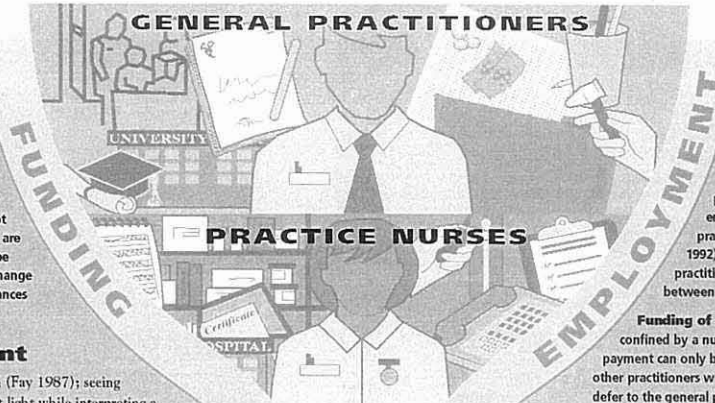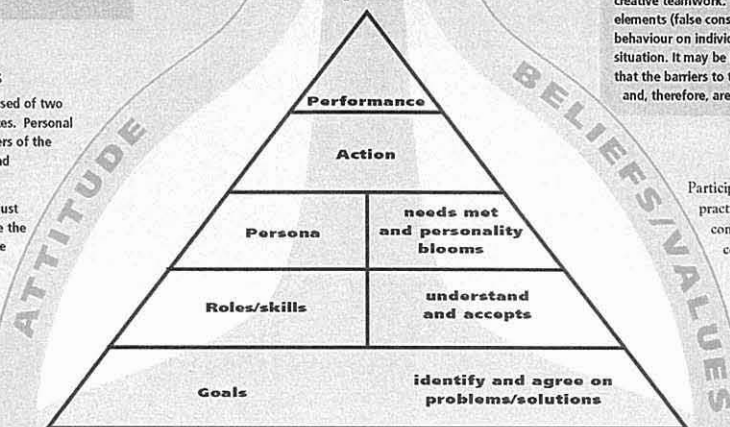
Barriers to Teamwork

Three main barriers were identified:

Traditional development of general practice: The current context of general practice is bound with the tradition of the stereotypical roles; that of the general practitioner as leader and employer and the practice nurse as assistant and employee.

Employment by general practitioners of practice nurses: The conditions of employment and the provision of the salary for practice nurses has been problematic (Hounsell 1992). This adds constant pressure to the general practitioner and broadens the collaborative gap between practice nurse and general practitioner.

Funding of general practice services: Payment is confined by a number of constraints. General Medical Services payment can only be claimed by general practitioners and not by other practitioners who carry out the service. Practice nurses need to defer to the general practitioner for him or her to oversee their own consultations.

Attitudes and Beliefs/Values of Role

Professional roles have a number of expectations placed on them by society or individual disciplines which are made up of a number of various values, beliefs and attitudes. Healthcare practitioners are generally aware that when they become a nurse or doctor they were entering recognised roles which carry implied duties and responsibilities.

The construction of role may have a constraining effect on creative teamwork. Role consists of a number of unconscious elements (false consciousness) which place an expected behaviour on individuals to conform within a social setting or situation. It may be because of these behavioural expectations that the barriers to teamwork are not conscious for practitioners and, therefore, are not challenged.

Role v Function

Participation in the focus groups brought to the practice nurses' and general practitioners' consciousness the hidden or unconscious concepts of functions performed within that role. The requirements to conform to expectations of a role can lead to further constriction and loss of freedom. This in turn may impede team members from exercising their skills and performing the functions necessary for achieving team goals. Traditional perceptions and expectations of professional roles may impede both the personal and professional attributes of individuals which could have a corresponding effect on team effectiveness.

Challenging the heirarchial structure may lead to ...

EMANCIPATION:
where teamwork is provided and adapted as required.

ATTITUDE — BELIEFS/VALUES

Performance	
Action	
Persona	needs met and personality blooms
Roles/skills	understand and accepts
Goals	identify and agree on problems/solutions

Heirarchy of need for a team
(using Maslow's hierarchy of needs model)

EMPOWERMENT

Re-defining Role for Effective Teamwork
using Maslow's hierarchy of needs for self-actualisation

1. Setting realistic goals which are accepted by team members.
2. Identifying roles and skills; agree and accept individual team member's contribution.
3. Attend to individual team member's persona and personal attributes.
4. Teamwork takes effect through action of 1, 2, 3.
5. Team performance will be the result of 1, 2, 3, and 4, ultimately leading to self-actualization of a team. This mirrors Maslow's five stages of self-actualization.

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