The "Double-Team" Approach in Medical Care Delivery

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Discussions concerning medical care delivery frequently include the phrase "team approach." This has a good sound and at first glance most people would agree that this might be a way to improve medical care. However, different people mean different things by "team approach" and, therefore, it is important in any discussion to define exactly what type of team is being considered. Depending on the kind of team, there can be diametrically opposed opinions as to whether it is "good" or "bad." In a recent article, Dr. Irvine Page used the phrase "health team" as if it were undesirable, implying that a team approach would de-emphasize the person and destroy the traditional doctor-patient relationship. He defined a health team as a group "consisting of many ill-dressed and inexperienced physicians and ancillary personnel whose credentials seem to the patient uncertain to say the least."[1] His definition is obviously different from that of many physicians who feel strongly that there are forms of team approach that reinforce rather than degrade the warm, personal doctor-patient relationship.

If it is ever possible to break away somewhat from the traditional one-to-one doctor-patient relationship in which each patient has to be seen or contacted by the doctor every time he becomes ill or needs medical advice, and if the disparity between the small number of doctors and the large number of people needing medical attention is to be improved, then some type of team approach will have to be utilized to permit the expertise of highly trained doctors to reach more people. One concept of team approach is that there are basically two components of the team involved in medical care delivery. This can be called the "double-team." The first component is composed of doctors working together, and the second, of the same doctors working in cooperation with health professionals who are not M.D.'s.

In Family Practice, and perhaps in some other forms of medical care delivery, the ideal doctor team would seem to be three doctors working together. This does *not* mean that each of these doctors has his own patients and the other two back him up with a call system. It *does* mean that these doctors *share* in the care of their patients. Patients and families who come under the care of these doctors realize that all three are their family doctors, not just one. This means that they have a more certain guarantee that medical care of a personal nature is always available, though not necessarily from the same doctor every time. It may happen that a patient sees one doctor more than the other two, and when this is convenient and the patient prefers it, this is perfectly acceptable. However, all three doctors should stay close enough in touch with the patient's condition so that there will be no difficulty for any one of them to take over when another is off duty. All three doctors should give personal, sympathetic attention to their patients' problems. The team approach does not mean that the good doctor-patient relationship is impaired.

The other component of the double-team involves the use of allied health professionals. The ideal arrangement here involves one or two physician's assistants or nurse practitioners for each of the three doctors in the group, making a total of three to six allied health professionals and three doctors. These health professionals should operate as a team with the doctors and *share* in the management of patients. Allied health professionals and doctors should work together under the same roof so that consultation by the doctor and assistance by the allied health professional are constantly available at the request of the patient, the doctor, or the assistant.

Most of the health care today is delivered by doctors trained in solo practice. They performed in this fashion throughout medical school and residency. Even some of the residency programs which nowadays claim to use a team approach actually do nothing so far as *sharing* patients. Their team approach consists of a multiple backup system which is no better than several doctors taking call for one another and is really not a cooperative effort in the most true and valuable sense. The important thing today is to structure training programs so that the double-team approach is incorporated from the very beginning. Medical students and residents should be assigned patients together, so that they share in their management. In addition, medical students and residents should work in close cooperation with allied health professionals from the outset of their clinical experience. Only with this type of preparation will the new breed of physicians feel at ease when they enter practice in a team situation.

If the fields of medicine which involve *delivery* of health care, such as Family Practice, the day of the solo practitioner should be over. It is a waste of this country's resources to educate solo physicians. In fact, part of their education should be in why *not* to be solo. At the same time as team cooperation replaces solo isolationism, the emphasis on personal care to individuals in a pleasant doctor-patient relationship should be stressed more than ever. The lack of ideal doctor-patient relationships in a medical community made up primarily of solo practitioners certainly does not argue for the theory that solo practice guarantees good doctor-patient relationships. Perpetuation of the solo system will not insure emphasis on the art of medicine. Actually, the sharing of patients by a team should foster a deeper and more considerate approach to the patient. The doctor is less likely to speak harshly to a patient or to shortchange him in personal concern if he knows that one or two other doctors are equally involved with the patient. An irritating patient is less likely to exasperate the doctor if the doctor knows that he does not necessarily have to see him every single time in the future. Doctors are less likely to play God almighty if they are diluted three times. They are also less likely to perpetuate their own errors as is common in the case of solo practitioners who practice for years essentially unobserved by their colleagues.

The objective of the double-team approach is to provide better continuous and comprehensive care to larger numbers of people, while at the same time maintaining and even strengthening the doctor-patient relationship. This appears to be not only a realistic goal but also a much needed one.

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Reference

1. Page IH. The doctor-healer, confidant, and friend. *Mod Med* 40(7): 46-47, 1974.