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technologists, and so on—a pattern found in myriad small practices dotting the United States.

Concurrently, many groups sought to introduce and develop primary care teams. In 1915, teams of physicians, health educators, and social workers were developed at outpatient areas of Massachusetts General Hospital. Efforts to create functional primary care team models continued at New York's Montefiore Hospital in 1948 and at Yale in 1951. Then, in the 1960s, neighborhood health center programs sought to establish primary care teams in area clinics.

However, the use of primary care teams did not become dominant because of several barriers. One barrier was the tension between physicians and nurses regarding their respective responsibility, authority, and knowledge. Another obstacle resulted from payment systems that primarily paid only for physician-related services and failed to reimburse nonphysician work. In addition, team relationships during the 1960s and 1970s were vaguely defined and not based on training or clear divisions of labor. Team meetings became drawn-out, unproductive affairs.

Large teams were difficult to manage in primary care. Some experts assert that optimal primary care teams should include between 6 and 12 people. Even in teams this size, however, decision making can be problematic.

The activity of building new teams involves creating alternative systems of care delivery. Processes must be changed and decision making must be transformed. These efforts do not occur overnight and may take years to accomplish fully. But ultimately, the rewards of improved quality and patient satisfaction will be worth the effort.

Source: Information from Bodenheimer (2007).

Case Questions

1. What were the barriers to forming primary care teams?
2. Why might the forming of teams be more difficult in primary care settings than in single-specialty physician offices or other businesses?
3. What could have been done to strengthen teams over the history of healthcare delivery?