A symposium on patient-centred care in the context of teamwork: challenges and innovation. UNSW Research Centre for Primary Health Care and Equity

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Reflections on the day – Tom Freeman

- Any discussion of team care in primary care and family medicine must take into account the context of practice. Two papers that appeared in the Annals of Family Medicine in 2005 are particularly relevant. In the first (Martin Fortin, Gina Bravo, Catherine Hudon, Alain Vanasse, and Lise Lapointe **Prevalence of Multimorbidity Among Adults Seen in Family Practice** Ann. Fam. Med, May 2005; 3: 223 - 228) Fortin and colleagues examined the prevalence of multimorbidity in family practices in a region of Quebec. This was based on the patients sitting in the waiting rooms of participating practices and included a review of their charts. They found that 9 out of 10 had more than one chronic condition and 50% had 5 or more chronic conditions. In the same issue of the journal, Ostbye et al (Truls Østbye, Kimberly S. H. Yarnall, Katrina M. Krause, Kathryn I. Pollak, Margaret Gradison, and J. Lloyd Michener**Is There Time for Management of Patients With Chronic Diseases in Primary Care?**Ann. Fam. Med, May 2005; 3: 209 - 214) constructed a virtual panel of 2500 patients reflecting the demographics of the U.S. population and the known community prevalence of the top 10 chronic conditions. They calculated that each condition would require a minimum of 1 or 2 visits/year depending on the condition, to monitor and adjust medications and ensure adherence to clinical practice guidelines. Depression was calculated to require 4 visits/year. These are conservative estimates. If each review takes 10 minutes, then just to apply existing guidelines for these 10 conditions would require 3.5 hr/day in a working year of 47 weeks assuming 41.3 hr/week of direct patient care. If the conditions are unstable, then the time becomes 10.6 hr/day. This, clearly exceeds the capabilities of practitioners especially given other patient care needs. Two conclusions: guidelines based on single disease entities are of limited usefulness in the world of multimorbidity; we should be studying and celebrating how general practitioners actually achieve the results they do in such a milieu.

- We learned today from Moira Stewart's presentation that natural collaborations exist in community practices prior to any health care reforms. They arise organically as practices find the services needed by their patients. They are connected to the environment of community services. Despite these nascent teams and networks, we have seen in NSW and Ontario a tendency to apply a top down approach to strengthening primary care rather than building on what is naturally there.

- Another theme we heard today was that of mismatch. From Tim Shortus, the different views of general practitioners represented by primarily biomedical orientation or personalized care orientation. From Lydia Yuen, a mismatch between the expectations of doctors and patients about the purpose of referrals for diet counseling. From Christine Walker, a mismatch between patient needs and the ability of the system to recognize or respond in a meaningful way. I think these mismatches are rooted in two fundamentally different ways of viewing ill health. The biomedical or ontological view sees diseases as discrete entities that afflict people. This view invites the response of attempting to cure through medical or surgical interventions. Since diseases are the same or similar across many dimensions, the expectation is of standardized

outcomes given effective approaches as determined by the evidence. This is mediated through clinical practice guidelines and de-emphasizes taking into account of the broad determinants of health. The alternative point of view is called the Hippocratic or holistic view and sees ill health as arising from an imbalance between the patient (genetic makeup, early childhood experiences etc) and the environment (physical, psychological, social, environmental, spiritual). This viewpoint is less likely to seek cure and more likely to seek adaptation responses; variation is the norm as no two patients are alike; the broader determinants of health are very relevant. These two views are represented in Greek mythology by the goddesses Hygeia and Panakea and generally both are present in some way throughout history though one or the other is generally dominant at any given time. Since the early 20th century the biomedical approach has been dominant in the developed (and sadly, in many developing countries as well). It has been seriously questioned since the 1960s.

- It is useful to look at team based care as a form of technology using that word in its broadest sense as a way of doing something. Ursula Franklin is a Canadian who has written about technology in her book The Real World of Technology. She distinguishes two forms or models that technology may take. In the production model, a task is broken down into a number of discrete steps each of which is assigned to a worker. The overall process is overseen by managers and it reflects a culture of control. There is a clearly defined outcome and standardization is the rule. Examples in health care are some forms of hospital based care maps. In contrast, the growth model is more akin to crafts where a single or small group of workers are responsible for all aspects of the process. This is a much more contextual approach and variation is expected and, indeed, sought. An example is successful adaptation to disease/disability/death.

- As we develop teams that are appropriate for general practice and primary care I believe we must deliberately build them based on the growth model. In our discussions at UWO on cases where teams have worked successfully, one characteristic that seems to be important is that of the patient's story or narrative the elements of which are gradually put together during interdisciplinary team meetings. These narratives are a co-creation of the team and serve to encapsulate the emerging values and expressed preferences and provide a common language. They form the framework and a reference point that each health care provider carries into their interactions with that particular patient. The question that naturally arises is whether the patient would recognize the narrative that the team constructs. How do we ensure that patients take active part in assembling this narrative?

I was struck by the fact that here in NSW and in Ontario we are facing the same challenges in many ways. I believe it would be fruitful to continue these discussions and learn from each other as we progress.