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ARRANGING GENERALISM IN THE 2020 PRIMARY CARE TEAM

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EXECUTIVE SUMMARY

The Australian Primary Health Care System is at a crossroad. We are faced with a burgeoning workforce crisis, a complicated model of private and public health care funding, and changes to the scope of practice of GPs, nurses and other allied health staff who comprise primary care teams in Australia. Both the Canadian and United States health care systems provide useful contrasts to consider as Australia builds a National Primary Health Care Strategy. One element of health care is shared universally: patients will increasingly present with complex, multiple problems rather than a single disease. Neither the fragmented US system, nor the Canadian system with its stark provincial differences has overcome the challenges of developing coordinated, nation-wide responses that resolve team arrangements and inter-professional collaboration in primary care.

New developments in the U.S. in the Patient-Centred Medical Home (PCMH) movement signify important directions for health care. Canadian efforts to build a Pan-Canadian strategy to resolve provincial differences are also of interest. These developments signal that coordination of care across territorial and disciplinary boundaries is critical to the future of health care. The PCMH also indicates that the generalist (family physician or general practitioner) will be important to coordinate the health care of patients as they need continuity of care and a 'home,' or a place they can go to for medical care. Perhaps PCMH is also a movement that enables the important longitudinal relationships provided by general practitioners to their patients to be valued and recognised for their potential to improve health outcomes over time. Given that fragmented care and specialisation has eroded much of the gatekeeper and generalist function of family physicians in the US it is possible that the implementation of PCMH represents a yearning for generalist care.

As patient needs become increasingly more complex, those of us engaged in primary care research and clinical practice face moral and ethical questions: will single disease focussed strategies provide an adequate response to multiple, complex needs? What sort of teams will be needed for patients in the future? How will practitioners work together across disciplinary boundaries and divides to deliver high quality care? What infrastructure changes are needed to support new models of multidisciplinary team based care? Although Wagner's chronic care model in the US provides the components for chronic illness care, particularly the notion of a continuous healing relationship, it has not been explored in enough detail within Australia to provide contextually relevant answers. Family health team (FHTs) models in Canada have not resolved coordination of care issues and how teams work together inter-professionally either.

These international developments are but a snapshot of some of the examples that can inform the reorganization of primary care in Australia. In this study, we set out to examine these three examples of the PCMH, the Pan-Canadian strategy and the Family Health Teams to consider the relevance of our own work on generalism in relation to them. With this in mind, this brief report provides an overview of the linkage and exchange program undertaken during October-November 2009. Ideas were exchanged and developed with the Canadian Health Services Research Foundation (Ottawa, Canada) the Robert Graham Centre (Washington DC, U.S.) and the Centre for Clinical Bioethics (Washington DC, U.S). This has provided us with an opportunity to further consider how generalism can be arranged within the primary care team 2020.

INTRODUCTION: SETTING THE SCENE

The Australian Primary Health Care System has undergone numerous structural and financial reforms in recent years and these systems changes seem set to continue into coming years. The announcement in November 2007 to develop a National Primary Health Care Strategy (NPHCS) and the subsequent formation of the National Health & Hospital Reform Commission (NH&HRC) all demonstrate the commitment that the Federal government has to health care reform. These policy reforms also support arguments that there is a need to improve the coordination of health care policy and practice between States and Territories and that an overarching nation-wide vision for the primary health care system is necessary. With the Fourth biennial National Health Reform Summit to be held 2 and 3 March 2009 we can expect further discussions from consumers about their health care expectations, the social determinants of health, the public and private mix of health care in Australia, governance and structural reforms and effective primary health care to improve patient outcomes (AHCRA 2009). Absent, however, is a focused discussion on the values and principles required to underpin health care delivery and structural reforms. Such values and principles are central to developing not only a cohesive health care system, but an ethical one.

The important role of primary care is recognized in recent international policy developments with the release of the World Health Organisation's (WHO) report *Primary Health Care Now More Than Ever.* WHO (2008) calls for governments to resource and recognize the central role of primary care in the delivery of first point of contact, universal access at the level of individuals in their community, and for the provision of equitable health care over the whole of a person's life cycle. The NPHCS (DOHA 2008: 14) discussion paper acknowledges that multidisciplinary team based care is increasingly recognized as important to primary care but also notes considerable funding constraints that prevent achieving this vision. In addition to this there is a suitable lack of Australian evidence on how multidisciplinary teams will coordinate care and ensure continuity of care for patients. Moreover there is limited data on how primary care teams will be bound together and cooperate across disciplines and scope of practice issues.

Mays has previously noted that many reviews and syntheses, such as those funded by APHCRI and related to health care policy literature, mention the difficulties of employing evidence from international settings different to our own, yet,

> At the very least, one would have expected reviews explicitly to consider how findings from other countries and systems might have to be adapted, and, in turn, how certain preconditions might need to be in place for interventions known to be effective elsewhere to be implemented in Australia (2008, S45).

Mays' challenge is an important one but it does ask for something that is extremely difficult to achieve without adequate resources and funding. Additionally, the value of fully understanding and appreciating the contextual conditions and factors of other health care systems very different to our own cannot be emphasized enough. However, it is a fact, that it is difficult to examine in detail how to adapt findings from other countries with complicated funding structures, organizational variations and different physician and professional roles without contextual knowledge. Thus linkage and exchange programs provided through APHCRI offer invaluable opportunities to think about the sort of adaptation Mays mentions in a real way. Certainly, all good research needs to consider the available preconditions for interventions known to be effective elsewhere to be implemented in Australia. However, the solutions to these matters are complex and deeper contextual processes and values are important too. We need to understand, appreciate and fully evaluate systems that are different to the Australian setting and explore how our own research fits with these.

Thus, our linkage and exchange proposal set us on the task of considering a previously developed conceptual model of the essential dimensions of generalism as a philosophy of practice produced from Stream 6 workforce funding. We wanted to explore the relevance of this model to two very different health care systems in North America, Canada and the United States and to appreciate how this model might/might not inform future policy and practice developments in Australian primary health care. In particular the U.S developments in the patient-centred medical home, the directions and impetus of the pan-Canadian strategy and family health teams in Canada proved important examples to think about how our Australian developed research could inform this. Our aims were to link with some key research and policy institutions about findings from the narrative review and synthesis '*What is the Place of Generalism in the 2020 Primary Care Team*?' In particular, we were looking for research and information that might prove beneficial and inform the development and arrangement of multidisciplinary team arrangements in Australia.

The linkage and exchange program also provided an opportunity for international feedback from family physicians and other primary care professionals, and those engaged in policy on the conceptual model and the essential dimensions of generalism. This enabled us to consider the practical arrangements that may be needed to embed and strengthen generalism in the Australian primary health care system. It also provided us with a unique opportunity to ask international colleagues and policy related institutions for feedback on the value of the model and its potential for developing a philosophy of practice suited to primary care.

Our Stream 6 narrative review and synthesis on the place of generalism did encounter the old adage that 'the evidence from international settings is vastly different to our own'. Certainly, in the U.S. the term generalist was used to refer to broader sets of health care providers across first and secondary contact settings, while in Australia and the UK the term generalist meant general practitioners (GPs) providing first contact assessment at the level of community. Our conceptual model thus had to adapt this material. The conceptual model is ultimately an interpretation on our part of where we think the 133 key themes documented from the literature reviewed fit within three essential dimensions. The three essential dimensions were not presented explicitly within the literature or used to explain generalism or the generalist approach, features of them were referred to by different authors but we could not identify this mode of explanation within one text or body of work. We took serious the laments that specialization and cost-effective measures could result in a loss of something unique that generalists offered. We believed that the erosion of humanistic and social values important to generalists and the generalist approach -- as others put forward -- provided a unique way to deliver primary care. The review had already found that:

- limited agreement existed on a definition of generalism;
- there was a lack of evidence in the Australian setting of how a generalist approach delivers equitable, accessible, cost-effective care for patients;
- alarm continued about the devaluation and reduced emphasis on generalism, and concern was growing about the increasingly complex knowledge and skills required to practice as a generalist (Gunn et al., 2007; Palmer et al., 2007).

The Stream 6 review identified three core policy areas where attention could be given to these issues: **increasing** the importance and status of primary care generalists, **enhancing** education content and settings that strengthen a generalist primary care workforce, and **building** and **transferring evidence** about strategies that strengthen generalism in the 2020 primary care team (Gunn et al., 2007: 34-36). Options for policy and research activities to achieve this were provided in the final report available at http://www.anu.edu.au/aphcri/Domain/Workforce/Gunn_25_approved.pdf. The linkage and exchange program thus presented an opportunity to further advance generalism as a philosophy of practice either for primary medical care or the broader primary care team.

OUR LINKAGE AND EXCHANGE APPROACH

Our linkage and exchange proposal sought to link and exchange ideas about our conceptual model and to ask people about the essential dimensions and features of generalism from international settings and contexts different to our own. We sought feedback on the model's adaptability, relevance and whether or not there was support for it particularly by physicians. The linkage and exchange program aimed to: *model examples of primary care teams underpinned by generalism which are responsive to rising co-morbidity and multi-morbidities and enable the scope of practice issues to be explored.* This was an ambitious aim given the difference in team care arrangements in Canada and the U.S. However, the examples of the patient-centred medical home (PCMH) and the family health team (FHT) arrangements in Canada provided two key examples to consider the conceptual model in relation with. In line with Lomas' (2000) linkage and exchange model, our visits enabled us to increase 'contextualisation (i.e. relevance and use) of evidence for policy-making'. Our goal was to gather evidence that might inform present and future policy directions in Australia, particularly around the issue of multidisciplinary teams.

Three initial outcomes were put forward for our visits:

1. Through dialogue, discussion and learning from our colleagues to examine preferred practice models for the Australian setting.
2. Documentation of discussions with international colleagues to conduct modelling of primary care teams underpinned by generalism and to collectively construct a multi-authored, multi-sited publication from this work.
3. Development of these models through the fellowship could form the basis of developing an intervention for experimental testing in Australian primary care settings.

To achieve these outcomes we sought the perspectives of key researchers at the Canadian Health Services Research Foundation (CHSRF), the CT Lamont Research Group, the Robert Graham Centre and The Centre for Clinical Bioethics on our conceptual model of the essential dimensions of generalism. We discussed the possibilities of using this model as a basis for developing a philosophy of practice suitable to primary care. Professor Kurt Stange joined us in Washington DC for an intensive two day discussion on the conceptual model and the patient centred medical home a part of our linkage and exchange program. Our search for these perspectives began with our presentation of the Stream 6 research to groups for which it is helpful to provide a brief overview of herein.

LOOKING FOR PERSPECTIVE

There is an old Indian fable which tells of the blind men and the elephant…

> *…A long time ago there was a poor village where all were blind. One day a strange creature called an elephant appeared at the edge of the village. Since no one in the village had ever encountered an elephant before, the four wisest of the blind villagers went out to discover what the new creature was like. They all felt the creature. The first wise man touched the elephants tail and felt the strong, bending twin and the coarse fibres on the tip and exclaimed, "this creature is very much like a rope". The second wise man stepped toward the front of the elephant and he felt a squirming object, which was the elephant's trunk, curl about his waist. "Aha!" he declared "this creature is like a python". The third wise man chanced to touch the elephant's ear and he at once cried out, "this creature is like a mighty fan". The fourth wise man shuffled towards the elephant and came across one of its stout legs. Feeling it with both hands, he cried out "this creature feels exactly like the trunk of a great toddy palm".*

> *Then, the four wise men began to argue about the nature of this creature each drawing from his own experience…after all each had felt the creature for himself and each believed that he was right…and, indeed, each was for, depending on how the elephant is seen, each of the wise men was partly right even though they were all wrong. And so they argued, and as they argued, the mighty elephant slowly trundled away its trunk and its tail swishing from side to side….*

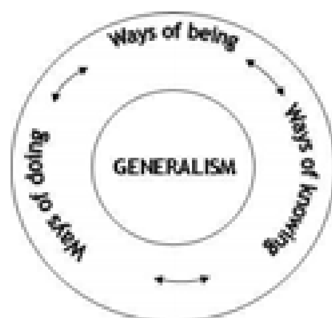
A key message for our linkage and exchange program was to think about perspective and the ways in which individuals approach the problems of primary care from different vantage points. How we see the world and who people are within it will affect the philosophical preferences we have and the values and principles that we think are important. Perspective can be an often overlooked aspect of policy and research, and indeed within clinical practice too, it is easy to take for granted that everyone agrees on what is important. Perspective is very important also for professional collaboration and central to health care. Effective team work requires everyone having a shared understanding of what the work is and how each person can contribute to completing that work. Shared understanding begins by developing an understanding of the different perspectives people have, the different ways that we see problems and opportunities. By learning the different perspectives we bring we learn to appreciate each other's differences and similarities. We wanted to encourage a sense that we all bring different perspectives to bear on the matters of health care, we are confronted with competing interests and it is important to foster a sense of dialogue and exchange around this. Taking these ideas, we presented the theme of perspective as a central element within our presentation of using the conceptual model of generalism as a basis for developing a philosophy of practice. We explained our perspective that a philosophy of practice was important for presenting professional viewpoints and for appreciating individual differences. Indeed, having a coherent philosophy would mean that there was an ability to articulate core values and principles that are central to the profession. The presentation shared our primary research findings on the conceptual model and concluded with a visual representation premised on the notion of perspective. Table 1 shows the conceptual model of the essential dimensions of generalism as a philosophy of practice. Figure 2 shows the visual representation of perspective we identified and developed.

Table 1 Conceptual model: The essential dimensions of generalism as a philosophy of practice

Dimensions of Generalism	Explanations: the key features
Ways of Being (Ontological Frame)	**Virtuous character:** holds ethical character traits of compassion, tolerance, trust, empathy and respect.
	Reflexive: interdependent, reflects on judgments and biases, lifelong learner.
	Interpretive: processes of interpretation are used to understand patient with an emphasis on the contextual factors, use of multiple health systems languages, active listener, autonomous decision-maker, good communication skills.
Ways of Knowing (Epistemological Frame)	**Biotechnical:** uses scientific and rational evidence, high index of suspicion, bio-medically driven, technically focussed, uses advanced information systems.
	Biographical: concentrates on lived-experience and life-story, family, carers, community and social knowledge all provide evidence.
Ways of Doing (Practical Frame)	**Access:** accessible, first-contact point, gatekeeper, provides referral.
	Approach: balances individual versus population needs, consultation-based, holistic, comprehensive, flexible, adaptable, acts across clinical boundaries, provides early diagnosis, interdisciplinary team approach, negotiates & coordinates services, integrates knowledge, promotes health through education, prevents disease, is culturally sensitive, provides patient-centred care, minimises service inequities, reduces service fragmentation.
	Time: provides continuity of care over whole of life cycle (longitudinal).
	Context: community-based, uncertain, complex, deals with undifferentiated multiple problems of patients, acute and chronic care.

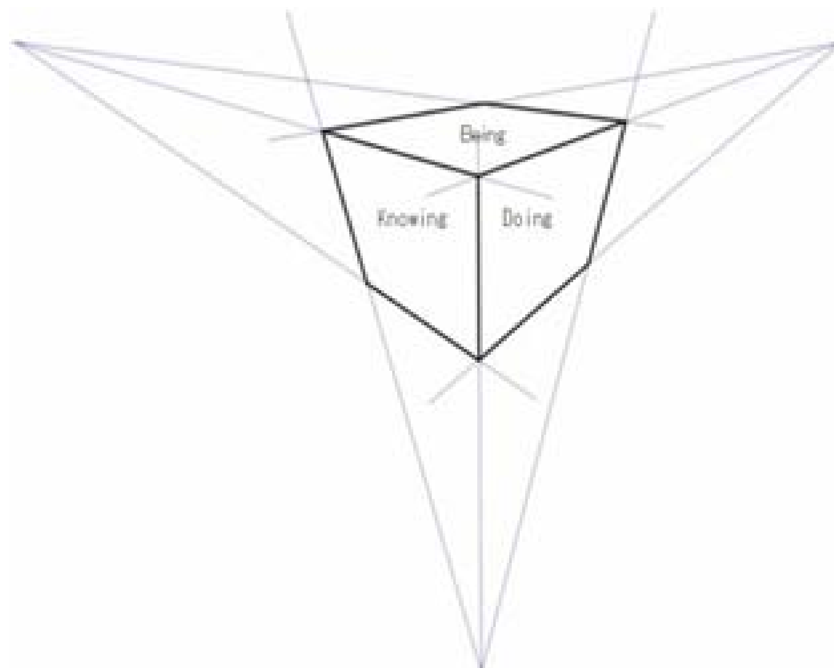
The presentation explained that the model represented a synthesis of the literature review which was largely material written and published by family physicians and academics. After identifying some 133 themes from 97 collected papers, the review team established that they naturally feel into the three dimensions of: 'being' (who the person was – the important values and principles and character), 'knowing' (what knowledge is used and important) and 'doing' (how character and knowledge influence practice). 64 papers formed the core literature that was synthesized within the model. The presentation emphasized that this material was likely to look familiar to all family physicians present (at least we hoped that it would) and that this was a synthesis thus it brought together the essential dimensions into one place but might not necessarily be anything new to people. We believed it was important to convey our perspective to people that the interaction of the three dimensions as a continuum was critical for understanding practice. The continuous interaction was meant to signify the need to give importance to all three dimensions not one more than another. Figure 1 shows the continuum of interaction between dimensions.

Figure 1: Continuum of interaction: dimensions underpinning a philosophy of practice



The presentation moved on to suggest that these essential dimensions of generalism as represented within the literature and the underpinning features represent a potential philosophy of practice for primary care. This is because all philosophies need to consider who people are (ontological frame), there needs to be clear articulation of what they know and how they explain the world through these theories of knowledge (epistemological frame) and they need to explain how the work is done (practical frame). To date, as the narrative review and synthesis had shown, greater attention had been given in both academic and policy literature to the 'doing' of the generalist work. Some attention had been given to epistemological differences between generalists and specialists and how knowledge was used differently in family medicine, but there had been almost no attention given to the ontological dimension. However, a key aspect of all of these dimensions was how they were influenced and constructed by perspective; our fable presented at the beginning of this section assisted with sharing that message. Prior to our presentation we had also explored some potential diagrammatic representations of the model. We found that an image used to teach perspective within art was most useful. This is shown in figure 2.

Figure 2: Perspective



Explanation of the diagram: excerpt from our presentation

> ...Dimensional analytical geometry tells us that the shape of an object is not only determined by its lines but also by the position of the observer. Thus how we see the image is influenced not only by its representation but where we are standing in relation to it...

> "The conceptual model of generalism represents ideals that might be valued or seen differently by others. We think that this image which is used in art to teach perspective is a useful way to visually represent the conceptual model. It shows the three dimensions all together with the being frame at the centre. We can see that these frames have lines drawn from them going outward into the distance and representing the infinite possibilities of developing generalism. One might also see the different features of each dimension plotted along these lines coming out of each frame in terms of importance – i.e. for being

the way that one person holds character traits as important in their delivery of care might be closer and other parts further out. Or put another way the different features might be plotted along the line in different positions according to the way that each encounter demands a different application of them. The point is that the conceptual model is not static and held in time, it changes and exists in relation with people who receive care. So this diagram assists to give the model a spatial dimension that exists in time, expanding and contracting."

We wanted people to remember our message about perspective:

...*After all each had felt the creature for himself and each believed that he was right. And, indeed, each was for, depending on how the elephant is seen, each of the wise men was partly right even though they were all wrong.*

PERSPECTIVES FROM THE CT LAMONT RESEARCH GROUP

For the afternoon of the 28th October 2008 Dr. Palmer visited the research in progress series being held at the CT Lamont Primary Health Care Research Centre (see Appendix 1 for flyer information). Faculty member's shared their current research in progress through ten minute presentations that covered research projects, methods and areas of interest areas. It was a pleasure to hear about the funded studies of the research centre. CT Lamont Primary Health Care Research Centre is the research arm of the Department of Family Medicine, University of Ottawa. It is a centre within the Elisabeth Bruyere Research Institute (EBRI) and is a geriatric care facility with a palliative care unit. The EBRI is an old building and a hospital facility consisting of a rabbit warren of rooms and levels, one is easily lost within the palliative care centre but helpful staff will happily assist and take you to your location!

The purpose of CTLC is to provide empirical evidence to support decision makers in shaping primary health care locally, provincially and nationally. It is one of the largest health care research centres in Canada and its location in the capital, Ottawa provides the opportunity to have a greater reach to decision makers and health care policy departments. Following staff presentations Dr Palmer delivered the first presentation on the *conceptual model of generalism as a philosophy of practice for primary care* asking for specific feedback on its relevance to primary care teams in Canada and for information about team based approaches that could inform Australia. The group shared a number of perspectives and questions, recounted here from Dr Palmer's notes taken after presentations and recollections of discussions that followed:

Did presenting a conceptual model mean that the diversity of general practice would or could be lost – i.e. does the model ask everyone to be the same?

The question about diversity was raised by two people; one by UK BMJ editor John Fletcher and another by a GP who was adamant that endocrinologists practice in similar ways. I asked if she thought that the longitudinal nature of relationships was different, she felt that this was not specific to the family doctor only.

...I also responded in this discussion to people that I thought the development of a philosophy of practice may be more about creating a shared vision and shared set of language and understanding around generalist professions, rather than trying to make everyone the same. It seemed that people were concerned with losing diversity and difference with such a model being offered as a way of being for all primary care professionals. I also responded the concept of diversity in general practice itself was represented within the model particularly in the themes of the complexity and multiple problems and presentations. Such diversity of presentations also seemed to provide an opportunity to develop thinking and theorising about

a philosophy of practice so that professionals within primary care could articulate their responses and justifications for health care decisions.

Don't all professions share the values and principles put forward by generalists – is this just about good health care?

There were a number of people who commented that other professionals show these character traits. They wondered about what made generalists any different to other professionals. This question focused in on the ways of being dimension: it is not overly surprising that ways of being would be focused on as this is the dimension that examines what it means to be human – here at CT Lamont were a group of primary care professionals passionate about who they thought they were

...I replied that the focus is on generalism proper as a philosophy of practice, it is not one dimension over another but the whole of the picture, the interactions combined, that constitute generalism.

Would there be a pendulum shift back from specialism to generalism if such a shift had already occurred? Is not family medicine already considered a sub-specialty?

There is a possibility that with more complex problems the role of the generalist in coordination of care will be important. The road would be long in terms of medical education returning from specialist focus to generalist again and importantly both specialists and generalists are needed in health care. The Canadian Academy of Family Physician's put forward that general practice is a specialist discipline, I returned to a quote from a published paper out of the review that said, "generalists are specialists in spite of themselves". But, the key is that they are specialist at delivering a particular kind of care, using knowledge in particular way and focused on whole person care which is a uniquely generalist orientation unlike the specialist who focuses on parts of the whole.

How would the work apply to those outside of medical generalism i.e. what research is around in the other generalist disciplines?

When we conducted the narrative review and synthesis we did not find literature in nursing or social work that explored the important social principles and humanistic values of generalism in the same way. Nobody in this research group could point to research from these two areas that was similar.

What is unique or special about generalism – is there a danger in putting forward generalism as special or unique where it becomes exclusive and dominant itself?

There is a concern that professions see themselves as special and unique in a way that becomes exclusive. My response to this particular question was to say that what is important about the conceptual model of generalism is that values a dimension of health care that has been undervalued and that in the economic rationalist push it is important to value humanism and social side of care.

What are your impressions around the team context and the relevance of generalism with this? Do you have the impression of whether Canada is on the right track or not?

I explained that the team approach is not standardized in Australia and that was a key part of our visit to Canada. I suggested that research evidence from within CHSRF around the family medicine groups showed the challenges of working in multidisciplinary teams and inter-professional collaboration. In light of both these findings of key research it seems that vision is necessary, such ideas can only be further developed through thinking about the philosophy of practice that can underpin teams.

What was learned from CT Lamont

There was positive feedback from an epidemiologist who said that she often attended such presentations but did not understand them and she found this presentation very understandable and enjoyed it. The group seemed to find it a challenge to see how this conceptual model might be relevant for multidisciplinary teams because it had come so directly from the family medicine literature base. They were cautious about family physicians being presented as unique and special in terms of their values and principles, most of the contestation was directed at the ontological dimension which is not surprising given that the being frame focuses on identity questions. This presentation really enabled us to refine material and explain that the model was developed from a synthesis of literature directly written by family physicians and academics. We were able to direct future presentations in an exploratory manner to ask people if the model might apply to primary care teams broadly, the group did not ever really say which professionals comprised primary care teams in Canada.

PERSPECTIVES FROM THE CANADIAN HEALTH SERVICES RESEARCH FOUNDATION

Perspective matters. The CHSRF welcomed the Indian fable and were quick to remember how Jonathon Lomas had shared this fable himself in policy presentations to highlight how researchers and policy-makers think differently. The CHSRF group was supportive of the conceptual model of generalism and overall could see its relationship with team based approaches in Canada, this was in contrast to the discussion the previous day with CT Lamont research personnel. One representative from CHSRF did ask if the inclusion of 2020 had significance and if this meant that the model would change over time.

Emeritus Professor Brian Hutchinson felt that the conceptual model was applicable to the Quality Improvements and Innovations Partnership (QIIP) in Ontario which is focused on getting family health teams to work better together. He thought there were particular benefits in its use with multidisciplinary teams and getting people to articulate similarities and differences by using features of the dimensions. Others in the group commented that it would be interesting to hear from specialists about the model and others felt it provided 360 degree views of the team – this meant seeing the team as making up different parts of the whole. On the latter there were views that the conceptual model could also be used in an evaluative capacity, i.e. to assess if coherent teams reflect the qualities and characteristics within the model. One person had difficulties seeing how the model could be applied to a team within primary care in terms of sub-specialist practices. For example what did the conceptual model mean for a social worker or pharmacist within the primary care team? Such questions where echoed by other primary care professionals Palmer met in Canada.

Two days were spent with CHSRF their programs of research and policy activities were explained and discussed with Dr. Palmer at great length. Appendix 2 contains the schedule of meetings held at CHSRF. The CHSRF team shared key information about their Knowledge Exchange role, their Mythbusters program and the team focus, individual meetings were held with people from the following programs:

- The Teamwork Workshop network http://teamwork.igloocommunities.com/ this social network was developed for The Teamwork Workshop, Dec 2-3 2008 in Toronto, Ontario. It hosts updated information about the workshop, participant information, as well as helpful CHSRF teamwork resources, including summaries, decision support syntheses and more (see http://teamwork.igloocommunities.com/documents).
- Knowledge Summaries: to read more of CHSRF *Mythbusters*, *Evidence Boost*, *Promising Practices in Research Use*, and *Insight and Action* series, please visit

http://www.chsrf.ca/other_documents/knowledge-summaries_e.php. The summaries from all series that are relevant to teamwork, are available on The Teamwork Workshop network.

- Mythbusters Teaching Resource http://www.chsrf.ca/mythbusters/teaching-resource.php this resource walks through all of the steps CHSRF follows to produce a *Mythbusters*. It is intended for graduate instructors, but CHSRF have already seen interest from knowledge brokers working in decision maker organisations
- Executive Training for Research Application (EXTRA) program http://www.chsrf.ca/extra/index_e.php And to read more about the Intervention Projects component, in particular, please visit http://www.chsrf.ca/extra/projects_e.php

Coordinators of the Intervention Project also provided some information regarding projects that had been completed which could inform our generalism study. The following provide an overview of these studies and their focus. Staff also provided reports in full of these relevant studies:

Intervention Project (IP) title: Integrating Health Professionals into New Models of Inter-professional Care Delivery
Fellow: Faith Boutcher

IP description: The future of the health system is dependent on new, innovative models and practices that require inter-professional teams to collaborate in new ways (Orchard, et al. 2005). Most health professionals recognise that collaborative health care practices among professionals is essential to improve patient care outcomes. Despite the potential benefits of inter-professional collaboration, however, developing collaborative teamwork remains complex and a challenge in most organisations (Davoli, 2004, Lemieux, 2006). Effective inter-professional collaborative practice requires health professionals to understand their scope of practice, the scope of practice of other health professionals and their professional role limitations. A pilot project consisting of a scope of practice workshop was conducted to provide baseline data on clinical team's readiness to engage in inter-professional learning, to educate health professionals in the principles of inter-professional collaboration, increasing their understanding of professional roles among team members. Building well integrated, inter-professional teams that engage in collaborative care will achieve our organisational goals of patient safety, quality care and service, and fiscal accountability and is a strategic opportunity to establish "organisational readiness" for inter-professional collaborative care. A focus on principles of inter-professional collaboration – learning with, from and about each other in conjunction with the existence of a strong professional culture and strong senior level support will move collaborative practice forward; preparing the practice environment for a new generation of health professionals and to assist our clinical teams to fully engage in inter-professional collaborative care for improved patient outcomes.

Intervention Project (IP) title: Back to the Future: Primary Care Reform - A Systems Approach
Fellow: Debra Vanance

IP description: (not available)

Intervention Project (IP) title: Leadership Collaboration: Applying the Co-management Model for Evidence-based Change
Fellow: John Knoch

IP description: Health authorities can struggle with how to best structure an organisation to optimise decision-making after regionalisation. Current literature on this topic provides limited information on various models. This research noted comparable models such as Co-Management of environment resources; Dual-Management model in the Calgary Health Region; Program Management at Sunnybrook Health Science Centre, Toronto; Physician-Executive Leadership Team at Cranley Surgical Associates, Cincinnati, Ohio area; Executive Shared Leadership Model at Carondelet Health Network, Tucson, Arizona; and the Nurse-Physician Co-Leadership model at the Dana Farber Cancer Institute, Boston, Massachusetts.

The David Thompson Health Region in Alberta implemented the Co-Management dyad

model. The organisation realised positive results as reported by physicians and non-physician leaders functioning in the dyad. Respondents noted potential areas for improvement to the Co-Management model including time for physician leaders to participate, further integration of the model to other programs or departments and monitoring performance under this model. In addition, managers and frontline staff reported improved teamwork under the model in a separate Quality of Life Survey.

The new model offers a more balanced view of clinical and administrative components, improved physician involvement in decision-making, identifying clear reporting structures and providing a consistent approach to physician leader remuneration. The Co-Management model resulted in positioning the organisation to launch regional initiatives such as an obstetric best practice program, a regional laboratory test menu, a transparent selection process of leaders in the dyad and mechanism to introduce new medical bylaws.

The research noted the utilisation of an implementation framework developed by K.Golden-Biddle and EXTRA Cohort 3 (2007). The overall research design followed an experience based analysis research tool developed by A. Casebeer and G. McKean (2003). A major objective of the research was to identify theoretical components for the Co-Management model – collaboration, communication, competencies, complementary leaders and control as well as identifying tools necessary to implement the model. Although success was documented by the Health Region these results could not be achieved without the diligence of a committed senior management team.

CHSRF also hosted a telephone link-up for the emerging Pan-Canadian Strategy that Dr Palmer attended and a linkage and exchange round table discussion where key members were present from the *Mapping the Future of Primary Care Healthcare Research in Canada: A report to the Canadian Health Services Research Foundation* research team. The roundtable discussion focused on challenges around the implementation of family health team models in Ontario. Some held the view that change is only as transformative as the profession's readiness to change. CHSRF staff organised a meeting with a representative from the Office of Nursing Policy, Health Policy Branch at Health Canada which provided a unique opportunity to discuss and have feedback on the conceptual model of generalism we were putting forward.

There was a great deal of debate around the success of team based models in Canada and enormous differences of views about whether 'real' change ensued because of being heavily based on financial incentives. A critical point of discussion returned to the notion of **humanistic care** and the relationship of this with the presentation of the model that had been delivered. This group was curious about how humanistic care could be incentivised; though there were concerns about the unintended consequence of incentives. They felt the conceptual model might be used to identify the tacit features of organisations that might be the reason why some places provide high-quality care over others.

What was learned from CHSRF

A key insight from this session was how much Canada was looking to Australia and actively drawing on the Learning Collaboratives and Primary Care Organisations like the Divisions as exemplary practice models. The visit to CHSRF provided excellent ideas around linking policy and research more closely through programs like Mythbusters and provided great feedback on using the conceptual model at the team and organizational level. The Executive Training for Research Application (EXTRA) program coordinator, David, suggested that one way of using the conceptual model might also be within an intervention where someone takes the generalist conceptual model and tries to implement a generalist led team approach in one area and not in another.

The round table discussion actively encouraged thinking around the methods that could be used to measure the features and dimensions of the conceptual model. Measuring the model appeared to be an important next step in being able to demonstrate the importance of

generalism at the policy level and for debate around whether change will be facilitated by implementing financial incentives. On the latter, the group did not agree and the conceptual model was actively returned to as a demonstration point about the challenges of identifying what it is that makes care humanistic care and quality care. A final learning from CHSRF was related to the Pan-Canadian strategy and how Canada too faced the challenge of provincial differences much the same way that States and Territories of Australia do. CHSRF shared a number of reports also that related to teamwork and primary care which will be important in our future research studies.

PERSPECTIVES FROM THE ROBERT GRAHAM CENTRE, WASHINGTON DC

Palmer and Gunn both presented to the RGC. RGC prepared a flyer and circulated this prior to the event (see Appendix 3), ten people attended including an individuals from the National Committee for Quality Improvement who are actively involved in the implementation of the Patient Centred Medical Home. Four questions were provided to the group at the beginning of the presentation:

1) Do you think that family physicians in the U.S. are like this? Does the model resonate for you?
2) Do you think it is important to articulate the values and principles of the physician within the patient centred medical home?
3) What is the value of the model for policy reforms?
4) How would these dimensions be measured and why? Do they make a difference to health outcomes?

We had good discussion and feedback around:

- It being interesting to ask patients what they think of the model;
- If the model is a philosophy of practice, and if generalism is a specialty, and whether primary care does everything?
- The model and material seeming relevant for morale and even thinking about the concept of rehabilitation programs for bad physicians almost.
- Being worth measuring the essential dimensions of generalism for the sensitive, specific, valuable, valued and measurable and to develop competencies for these.

What was learned from the RGC

RGC taught us the importance of thinking further into measurements and provided us with support for our Stream 12 funded study due for completion in November 2009. The representative from the NCQI was interested in further follow up and suggested they would be in contact.

PERSPECTIVES FROM THE CENTRE FOR CLINICAL BIOETHICS, WASHINGTON DC

Dr Palmer visited The Centre for Clinical Bioethics at Georgetown University to discuss the conceptual model with Emeritus Professor Edmund Pellegrino. Renowned for his work in the development of a philosophy of medicine and his life long work as a general internist, Pellegrino provided excellent advice and discussion on theories underpinning the model and added new considerations to each of the dimensions of the model. He first proposed that the clinical encounter is shaped by the physician's duty to respond a patient's existential state –

their being that comes with suffering. The physician is compelled to ask, 'how can I help you?' Thus,

- *The being of the physician is shaped by the patient* (a good way to explain the interdependent nature of the physician-patient relationship);
- *Knowledge dimension is also about what we already know about the patient – what can we feel, touch and learn moving back to the wholeness of health*;
- *Combined being and knowing prompt us to consider: 'what can we now do for the patient?'*

Pellegrino also felt that it is important to highlight that the physician is not automatically the captain of the team but they do need to coordinate care. Two other family physicians were consulted at the bioethics centre, Father Jim Duffy and Marguerite Duane (Medical Director Spanish Catholic Center of Catholic Charities). Duffy agreed on the benefits of the model which he could see at work at his centre a PCMH and Duane suggested the model as a philosophy could be useful for teams to think about how all of the different parts make up a whole. Duane felt that the mentality of consumerism erodes healthcare, she felt passionate that this model would be important for education and training of professionals.

What was learned from the Centre for Clinical Bioethics

Time spent with Edmund Pellegrino was invaluable for developing theoretical perspectives and he was supportive of the broader ideas to formulate a philosophy of practice for primary care. Pellegrino also pointed us to important literature in philosophy and medicine. Physicians at the Centre provided important feedback and support for the model. Palmer and Gunn also had the privilege of attending one of Pellegrino's ethics rounds at the University Lombardi Cancer Centre held monthly. The case was presented from a paediatrician whom had recently joined the Centre and Pellegrino facilitated the discussion and emphasised the importance of seeing this in this case in the clinical context where a decision would have to be made:

> The paediatrician's previous team had been treating a 12 year girl on dialysis who had elected for a kidney transplant – she wanted a transplant not because of health status so much as for quality of life; dialysis was starting to impact on her social connectedness and ability to maintain friendships. The team went about completing investigations for a suitable donor, they invited the father to complete the compatibility test – the team knew that the father had only recently spent more time with his daughter and been mostly estranged for most of her life. The compatibility tests from the father revealed two things: he was a compatible donor, but he was not the girl's biological father. DILEMMA: Should the treating team tell the father the biological status?

DID WE ACHIEVE OUR INTENDED OUTCOMES?

KEY LEARNINGS

1. **No one site or setting has all of the answers**. We will need to use the strengths from different primary health care systems, including identifying those in our own, and create an evidence base of practice models that show how people can cooperate across disciplinary boundaries

2. **Overall very positive response to the model**. People are using it and applying it to the primary medical care setting.

3. **Support for the diagrammatic representation of perspective**. People liked the way that the perspective diagram could assist to explain how concepts are fluid

and expand and contract. While the conceptual model captures the essential dimensions of generalism it also represents these in a rather static way where their dynamic nature might be overlooked. There was feedback that the diagram on perspective could be used in a practical sense by multidisciplinary teams to explore differences and similarities in values. Team members might map their values and which parts of the essential dimensions are important along the diagram.

4. **Incentives do not assure that change happens in practice**. A key learning from these visits is that financial incentives will facilitate change but this does not always come with commitment to new values or better ways of practicing per se.

Examine preferred practice models for the Australian setting through dialogue, discussion and learning from our colleagues.

Further examination of the FHT model in Canada will be important for our continuing work on how to arrange generalism in the 2020 primary care team during 2009. The reports from the various intervention projects that have been undertaken via the EXTRA program will prove invaluable for considering inter-professional collaboration and primary care systems change. Synergies are evident between the conceptual model of generalism and the ideals of the PCMH, however, the PCMH risks becoming a financial structure with a loss of commitment to the values underpinning it if these are not clearly articulated and embedded within the model. The conceptual model may be beneficial for thinking about how to articulate and specify the important values to maintain such commitments. A key learning from these visits is that financial incentives will facilitate change but this does not come with commitment to new values or better ways of practicing per se. As such, the Australian government needs to approach financial incentives with caution. There are obvious benefits to multidisciplinary care in the context of multiple, complex problems however practice models will need attention and an evidence base to draw on in terms of people cooperating across disciplinary boundaries. We have identified via Stream 6 and 10 research, however, that a generalist led and coordinated model of care seems most effective for developing the future Australian health care system.

Documentation of discussions with international colleagues to conduct modelling of primary care teams underpinned by generalism and collectively construct a multi-authored, multi-sited publication from this work.

This report provides a summary of our documented discussions with international colleagues to model the arrangements for generalism in primary care teams. People supported the diagrammatic representation of perspective, being able to explain that concepts are fluid and expand and contract was important. There was feedback that this could be used practically by teams to explore differences and similarities in values. We gathered some key feedback about using that diagram with groups and asking people to place the concepts from the model along different parts of the line (further toward the horizon demonstrating less importance to them) and to explain why – we will attempt to pilot this activity in our continued study for 2009. Two multi-authored, multi-sited publications will result from the linkage and exchange activities in 2009:

Publication 1. (Working toward generalism as a foundational philosophy of practice for primary care)

Authors: Palmer V, Gunn J, Stange K. Could 'generalism' inform the development of a philosophy of primary medical care. Intended Journal: *Philosophy and medicine*

Publication 2. (What conceptual model offers to international examples)

Authors: Stange K, Phillips B, Palmer V, Gunn J. Implications and Perspective: a conceptual model of generalism and the Patient Centred Medical Home. Intended Journal: *Journal of Family Medicine*

Development of these models through the fellowship could form the basis of developing an intervention for experimental testing in Australian primary care settings.

Overall there was resounding support for the conceptual model of the essential dimensions of generalism providing the foundations for a philosophy of practice, although in Canada it did appear that interpretation of the model varied and people found it difficult to see the model operationalised at the level of the team over the individual. These are interesting contextual factors that ultimately affect adaptation. The RGC feedback intimates that hypothesis testing could be conducted from this research to identify if the model is useful, if it is useful for decision-making and planning, and if the model can assist to understand how decisions are made and who made them. A repeated aspect within discussions was how to measure the features within the model and whether or not the tactic dimensions within being and knowing could or should be measured. This may follow on from 2009 study that will: seek validation of the concepts and features of the model with patients and professionals and look at the arrangements of the concepts and features in terms of the relative importance for patients and professionals. This will culminate in an exploration of the relevance of the conceptual model of generalism for primary care teams in Australia. In addition to providing us with the opportunity to consider how the model could inform policy developments and reforms, our linkage and exchange experience has identified that there is potential for developing an intervention for experimental testing of generalism in the Australian primary health care setting.

FUTURE RESEARCH & POLICY DIRECTIONS

The conceptual model of the essential dimensions of generalism provides the basis from which to consider the development of a suitable philosophy of practice for primary care. Before we can achieve this, however, we do need to talk about the model with patients and other primary care professionals. Our 2009 APHCRI funded study will examine patient needs of the future, what patients' and other primary care professionals' value in this model and identify team care arrangements and where generalism will be placed within the 2020 primary care team. Common feedback from people during the traveling fellowship was that it would be interesting to have specialists comment on the conceptual model too. This feedback will inform our future directions and research. In addition to this we have maintained contact with Brian Hutchinson and QIIP program in Canada.

Brian wrote in December 2008 to inform us that he had shared our published MJA paper on generalism and Alma-Ata with QIIP colleagues, Nick Kates and Brenda Fraser, saying "we are exploring ways that your conceptual model can be incorporated into our work of facilitating team development, relationships and effectiveness among Ontario's Family Health Teams. We'll keep you posted and ask that you update us as your research progresses". (12/12/08).

The Robert Graham Centre have intimated that the conceptual model of the essential dimensions generalism has important implications for looking toward specifications of values to underpin and become embedded in the patient-centred medical home. The RGC have indicated support for testing the conceptual model in 12 months time. (16/11/08).

Tim. C. olde Hartman and MD, FP and PhD student of Department of Family Medicine, University Nijmegen Medical Centre wrote following hearing the presentation at a conference that followed on from the linkage and exchange visit:

> "In Nijmegen we have once a month an evening-meeting with GP residents who combine their residency with a PhD project (little group of 10-15 persons). On such evenings we discuss important topics, papers and papers in progress. I saw your presentation on generalism in Puerto Rico, and I downloaded the complete work from your website. Now I want to discuss your work 'what is the place of generalism in the 2020 primary care team?' during such an evening-meeting". (08/12/08)

Currently, our colleague and collaborator on this linkage and exchange program Professor Kurt Stange is exploring synergies of generalism research with the Future of Family Medicine Taskforce in the US.

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APPENDIX 1: CT LAMONT RESEARCH GROUP FLYER

C.T. LAMONT PRIMARY HEALTH CARE RESEARCH CENTRE

Research In Progress Rounds

CTLC Primary Health Care Projects Overview
&
A conceptual model of generalism as a philosophy of practice for primary care

Invited guests:

CTLC Principal Investigators & Dr. Victoria Palmer

The C.T. Lamont Primary Health care principal investigators will be each giving a 5-10 min overview presentation of their research projects.

Dr Victoria Palmer is a visiting academic in applied ethics from Australia and she will be presenting key research developments into "what is the place of generalism in the 2020 primary care team?" This paper introduces a conceptual model of generalism as a philosophy of practice for primary care premised on the important humanistic and social values of the generalist. Developed from a narrative review and synthesis of available literature, the foundation of this conceptual model rests on the continual interaction of three identified dimensions: ways of being, ways of knowing and ways of doing.
Dr Palmer is particularly interested to hear about the Canadian perspectives on this conceptual model and gaps or strengths people might see in it and the primary care team structure in place.

Date: Tuesday, October 28th, 2008 **Time:** 3:00—5:00 PM
Location: Bruyère Continuing Care, **Auditorium**, 43 Bruyère St.
Snacks will be served, please RSVP by October 24th to Ziad Chaar (zchaar@bruyere.org)

APPENDIX 2: CHSRF ITINERARY FOR FELLOWSHIP VISITS

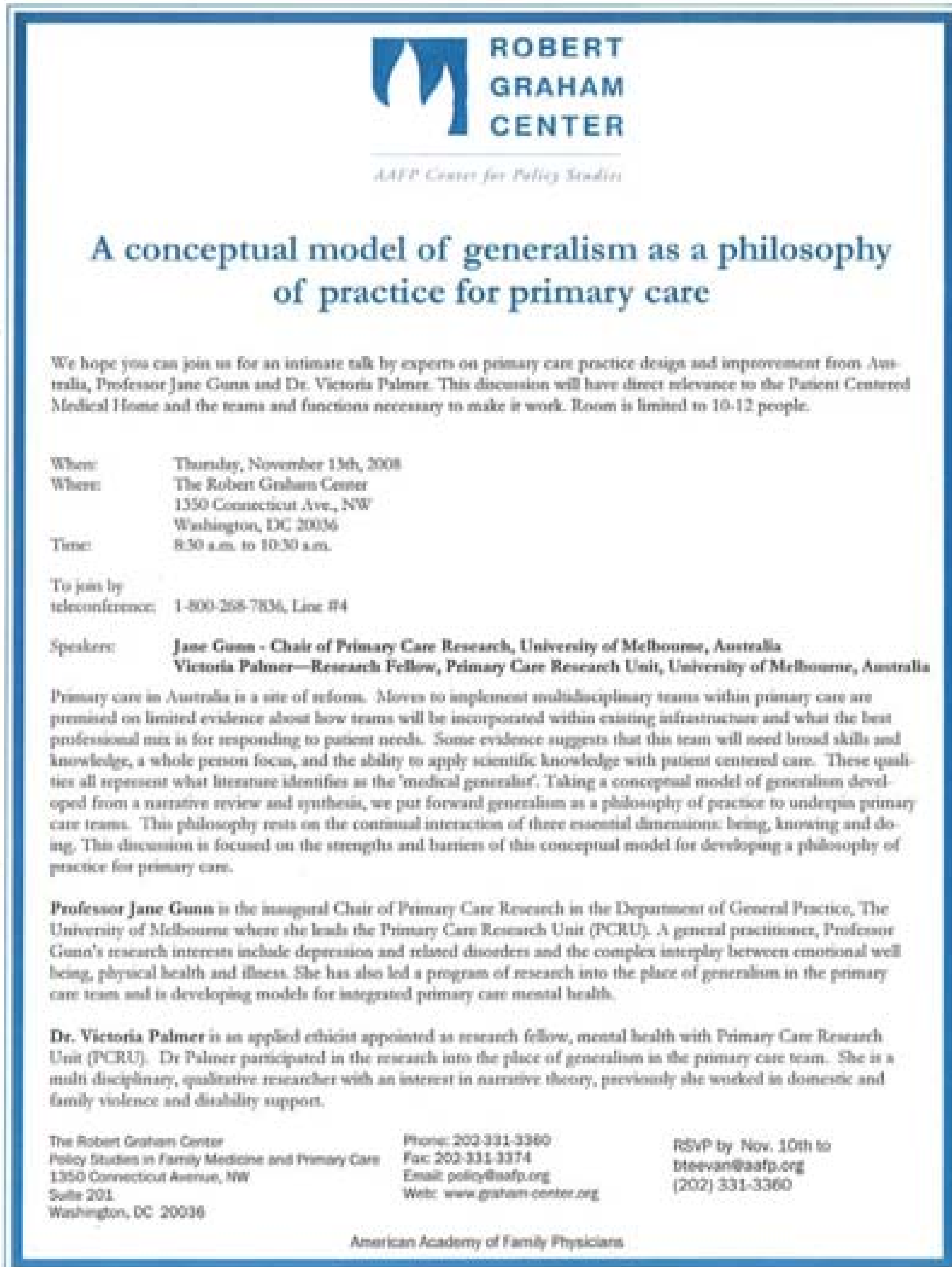
Itinerary for October 28 and 29, 2008
Dr. Victoria Palmer, APHCRI, Travelling Fellowship

Canadian Health Services Research Foundation
1565 Carling Avenue, Suite 700
Ottawa, Ontario K1Z 8R1
Tel: 613.728.2238

Tuesday October 28, 2008		
9:00 – 2:00	CHSRF internal meetings	
2:00 – 2:30	Travel to CT Lamont Centre	C.T. Lamont Centre Elizabeth Bruyère Research Institute 43 Bruyère Street Ottawa, Ontario, K1N 5C8 1(613) 562-4262x 1024
3:00 – 5:00	Presentation at CT Lamont Centre	

Wednesday October 29, 2008		
9:00 – 12:00	CHSRF Internal meetings	
12:00 – 1:00	Lunch with Brian Hutchison, Susan Law, Kevin Barclay and Gwen Gray	CHSRF Boardroom 3
1:00 – 2:00	Presentation to CHSRF staff	CHSRF Boardroom 1
2:00 – 3:30	*Teleconference – Canadian Working Group on Primary Healthcare Improvement*	CHSRF Boardroom 3
3:30 – 5:00	Roundtable discussion with Susan, Kevin, Brian, Victoria, Gwen, Grant Russell and William Hogg	CHSRF Boardroom 2

APPENDIX 3: ROBERT GRAHAM CENTRE FLYER



ROBERT GRAHAM CENTER

AAFP Center for Policy Studies

A conceptual model of generalism as a philosophy of practice for primary care

We hope you can join us for an intimate talk by experts on primary care practice design and improvement from Australia, Professor Jane Gunn and Dr. Victoria Palmer. This discussion will have direct relevance to the Patient Centered Medical Home and the teams and functions necessary to make it work. Room is limited to 10-12 people.

When: Thursday, November 13th, 2008
Where: The Robert Graham Center
1350 Connecticut Ave., NW
Washington, DC 20036
Time: 8:30 a.m. to 10:30 a.m.

To join by teleconference: 1-800-268-7836, Line #4

Speakers: **Jane Gunn - Chair of Primary Care Research, University of Melbourne, Australia**
Victoria Palmer—Research Fellow, Primary Care Research Unit, University of Melbourne, Australia

Primary care in Australia is a site of reform. Moves to implement multidisciplinary teams within primary care are premised on limited evidence about how teams will be incorporated within existing infrastructure and what the best professional mix is for responding to patient needs. Some evidence suggests that this team will need broad skills and knowledge, a whole person focus, and the ability to apply scientific knowledge with patient centered care. These qualities all represent what literature identifies as the 'medical generalist'. Taking a conceptual model of generalism developed from a narrative review and synthesis, we put forward generalism as a philosophy of practice to underpin primary care teams. This philosophy rests on the continual interaction of three essential dimensions: being, knowing and doing. This discussion is focused on the strengths and barriers of this conceptual model for developing a philosophy of practice for primary care.

Professor Jane Gunn is the inaugural Chair of Primary Care Research in the Department of General Practice, The University of Melbourne where she leads the Primary Care Research Unit (PCRU). A general practitioner, Professor Gunn's research interests include depression and related disorders and the complex interplay between emotional well being, physical health and illness. She has also led a program of research into the place of generalism in the primary care team and is developing models for integrated primary care mental health.

Dr. Victoria Palmer is an applied ethicist appointed as research fellow, mental health with Primary Care Research Unit (PCRU). Dr Palmer participated in the research into the place of generalism in the primary care team. She is a multi disciplinary, qualitative researcher with an interest in narrative theory, previously she worked in domestic and family violence and disability support.

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Web: www.graham-center.org

RSVP by Nov. 10th to
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American Academy of Family Physicians