THE TEAM IN PRIMARY CARE

A New Vision,
New Ways to Work

RECORD OF PROCEEDINGS

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APPENDIX 1: PROGRAM OVERVIEW
This record of proceedings provides a general summary of papers presented at the September 2002 Colloquium as well as exchanges between participants. It was prepared by an independent writer from recordings made during the plenary sessions, audiovisual documents used by speakers in their presentations and written summaries of workshop discussions.

Formal presentations as well as comments made by participants were organized according to broad themes and are not necessarily presented in chronological order. With few exceptions, they have not been attributed to their authors. This approach was taken to underscore the general spirit of exchange and collective deliberation that characterized the event.

This record of proceedings can only present a very abridged version of these papers and discussions. It has nevertheless been read, revised and approved by the Colloquium’s Scientific Committee, whose members consider it a faithful summary of the many contributions made and a balanced view of the many points of view expressed.
FOREWORD

Teamwork, 
One of the Keys to Accessible Primary Care

The Dr Sadok Besrou Chair in Family Medicine is concerned with primary care services. It’s mission is primarily to conduct research and make a contribution to the resolution of problems encountered in access to primary care and service continuity, across Canada and elsewhere.

One of the key ways this can be achieved—and one of the main issues being addressed by several health care systems around the world—is the creation of true primary care teams.

Effective solutions to problems of access and continuity can only result from close working relationships between the different actors involved. This was the core of the issue addressed by the Colloquium held in Montreal on September 19 and 20, 2002: the event was an opportunity for exchange between investigators, decision makers from different levels of government and practitioners actively engaged in implementing new ways of organizing primary care service delivery in Quebec, Canada and around the world.

The Colloquium gave over 150 actors an opportunity to engage in intense, rigorous and open dialogue. This report details the issues they identified, the obstacles they have faced and factors that have already led to some success in confronting these problems. Above all, it is rich in material that will be useful to anyone interested in pursuing, developing and expanding these ideas and this practice.

Dr Sadok Besrour,
Founder of the Dr Sadok Besrou Chair in Family Medicine of the University of Montreal
**Focusing on the Key Issue**

We are all engaged in a collective project to build a better health care system. It will be one that evolves as we search for more appropriate responses to the public’s health care needs and for ways to make better use of the means at our disposal. We are aware that this is a work in progress, a type of health care “Nintendo,” in which we are obliged to feel our way along, surmounting countless obstacles as they appear and fashioning solutions as we go. Some of us are further along this path than others, and some have even managed to get over (or around) major obstacles, emerging none too worse for the wear.

It was therefore time to come together and work toward a collective understanding of the dynamics behind this great reform initiative. The Colloquium held September 19 and 20, 2002 allowed 15 speakers and 150 participants to share their convictions and concerns, and discuss problems and victories.

In the course of our many exchanges, concerns were expressed about being able to retain the current system’s assets and the unique qualities of each of the professions. But the time when people dug their heels in over these issues seems to be behind us; these people can no longer prevent a serious discussion of change. Questions are still being raised, of course, and some still have reservations. What is new, however (and this augurs well for reforms already underway), is that we are now addressing these questions together, across disciplines. Instead of looking for answers on their own, actors seem to have decided to work together. If there were a single major issue to emerge from this Colloquium, it would be that the only way to meet these challenges is by keeping the focus on what is best for the health of our patients.

Marie-Dominique Beaulieu, MD
Holder of the Dr Sadok Besrour Chair in Family Medicine
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**The Scientific Committee**

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1. REFORMING PRIMARY CARE SERVICES

*Why? Toward what goal? How?*

Over the last decade, many industrialized countries decided to conduct comprehensive reviews of their health care systems. Existing systems no longer seemed able to provide an effective response to changing needs, available technologies, emerging scientific discoveries or clinical advances.

The general consensus was that the reform of primary care delivery would play a key role in solutions to the systemic problems in health care.

The specific types of reform undertaken may have varied, according to the national or provincial context, but generally speaking, they have addressed the same kinds of problems by setting the same types of objectives.

a) Why?

**Inadequate staffing, and personnel who do not collaborate enough**

Whether in Quebec, Ontario, Alberta or Australia, the perceived need for primary care reform has generally resulted from the same observations:

- There have been significant shortcomings in the system’s abilities to provide access to services, continuity of care, and follow-up care;

- There has been a lack of integration, co-ordination, flow of information, and collaboration among primary care service providers and second-tier services. This observation also applies to working relationships between actors in primary care [more specifically, in Quebec there has been a lack of integration between primary care practices and the network of community clinics (CLSCs)];

- Health care systems have tended to be too dependent on curative and hospital services and have not put enough emphasis on prevention activities.

These observations drew no debate during the Colloquium, nor did they receive much attention during the exchanges among participants; rather, they formed the basis of and served as a point of departure for discussions. It was noted, however, that the current round of Canadian reforms have not been the result of problems in the quality of services delivered. On the contrary, studies have shown that services provided by family physicians are among the most appreciated by the general public. While this may be true for Canadians who have access to these services, the same cannot be said for the 30% of Canadians who do not.

*In Canada, the problem is not the quality of primary care services, but rather poor accessibility.*
**Understaffing and/or inappropriate methods of practice?**
Some participants believe that the shortage of family physicians and nurses (including adequately-trained nurses) is not only the main cause of the problems in primary care today, but also represents the main obstacle to implementing reforms. Furthermore, these participants do not believe it possible to solve this problem by simply reorganizing the work of family physicians or giving nurses new responsibilities.

Other participants, however, noted that higher staffing levels will not be a panacea, and that perhaps the time has come to take a fresh look at staffing issues. Rather than ask how many people the system requires in each profession, we might want to take a closer look at the skills and competencies required if we are to provide an adequate response to needs. Clearly the shortage of medical and nursing staff must be addressed, because an effective response to needs will not be possible under current staffing levels. However, we must also find new approaches to practice and service delivery that will be more appropriate to changing needs. *Simply put, we must now have a coordinated effort, making progress on both fronts simultaneously.*

**b) Toward what goal?**

*A consensus on objectives*
Generally speaking, all the measures that have been proposed or implemented in current reforms are designed to accentuate or reinforce the contribution made by primary care services. Their goal is to allow these services to fulfil a specific role in improving the health of the population served. In addition, by making primary care the usual point of entry into the health care system, these measures are designed to reduce the pressure on second- and third-tier services and encourage a more judicious use of resources.

Primary care services are usually reinforced by creating structures, mechanisms and conditions that encourage:

- The specific nature of primary care’s contribution to public health (such as a comprehensive approach centred on the individual, multidisciplinary teamwork, a focus on prevention, or patients taking responsibility for their own health);

- The public’s quick and continuous access to routine care at a location near their community (this can include offering a range of routine services, giving professionals access to relevant information and technical support, and providing various means of ensuring service availability 24/7);

- The continuity of services (such as a mechanism to ensure follow-up, the co-ordination of care, flow of information, and an effective interface with second-tier services).
A Common Vision

In an article in *Le Devoir* in November 2000, Dr Denis Roy proposed a vision of a health care system defined from the point of view of the “citizen, client and taxpayer.” Here is a brief overview of what he proposed.

First and foremost, a good family physician
My family physician would be someone who knows me. He or she would work in a team of 8 to 10 family physicians that would include nurses involved in educational activities and patient management. It would have agreements in place through which team members would have access to professionals working in the local community clinic. My physician, working with a nurse on the team, would be able to give me advice based on my needs. He or she would work closely with several other physicians in the region and be a member of a regional department of general medicine. Part of his or her compensation would be set as a function of my profile and needs.

Among the Colloquium’s participants who responded to our survey;
• 88% were in general agreement with this vision,
• 62% thought that working in a multidisciplinary team represented its most important aspect,
• 23% did not agree with what was said about compensation.

The main reasons why this vision should be realized are:
• its ideas on teamwork,
• the way experience is shared,
• the way change is managed,
• how the work is organized in a network.

The main obstacles to achieving this vision are:
• a lack of human and financial resources,
• resistance to change,
• barriers between disciplines.

c) How?

◆ Approaches and methods employed in Ontario, Alberta, Quebec and Australia
Four examples of primary care reforms were presented to stimulate discussion among participants. Before discussing what these examples have in common, we will provide a general description of each case.

Ontario’s Family Health Networks
In Ontario, reform has involved the implementation of local Family Health Networks. Physicians and other health professionals are free to join a network, but encouraged to do so through financial agreements.

A Family Health Network
• A network consists of at least five family physicians who have freely decided to collaborate with each other and other health care professionals (in particular, nurse practitioners). The network supplies accessible, co-ordinated care to patients who have also freely joined it.
• The network must have a formal governing
After the network concept was tested in pilot projects, the terms of implementation were established through an agreement with the provincial physicians’ association.

The government invested $250M in the implementation process: $100M to raise the revenues of family physicians and $150M for the computerization of medical practice and related networking with hospitals and laboratories.

A new provincial agency, the Ontario Family Health Network, was created to oversee and support the process of implementing this reform to primary care services. Under an agreement with the Ontario Medical Association, since 2002 this agency has been able to propose networking agreements to all family physicians practising in Ontario.

As of this day, pilot projects and ten other Family Health Networks have begun offering services under this program.

Benefits are already apparent

Initial evaluations of the Ontario experiment clearly show that the network model benefits patients, physicians and the health care system.

- **Patients** can count on improved access to primary care, better co-ordination of services and more continuous care, with a focus on prevention.

- **Physicians** in such a group enjoy numerous and varied benefits.

  - They can count on more stable and predictable revenues, and this gives them greater freedom; they can, for example, participate in training activities or sessions without concerns about lost revenue. In addition, the new method of compensation recognizes and rewards a comprehensive and preventive approach to health care.

  - They found that joining a network presented an opportunity to make improvements to the organization of their practice and, through computerization, ensure that clinical information can be followed more closely.

  - Various measures introduced as part of network membership also improved their quality of life. Sharing on-call responsibilities or the implementation of a clinic outside of regular office hours allows physicians more flexibility in how they organize their work, while they are assured that...
patients receive the necessary attention and the patient’s file will provide a full accounting of the care provided.

- Overall, the health care system benefits from the use of family health networks because emergency services are used more judiciously, family physicians are easier to recruit and hold on to, and the public enjoys better health.

**Alberta’s Primary Care Initiatives**
Primary care reform in Alberta was put back on the agenda after health care services were decentralized. Pilot projects were financed by transition funds coming from a variety of sources. These projects tested various types of networks, including family practices, multidisciplinary teams and a common approach to care.

It was the family physicians themselves, and not professional associations or the government, who assumed the leadership of this reform. The physicians chose to network through partnerships or strategic alliances, signing formal agreements that would let them work together toward a common goal. Regional health care authorities and the government have chosen to play a supportive role.

In the Calgary area, reform took the form of Primary Care Initiatives; groups focused on the practice of family medicine rather than on the family physician.

The networking of these practices, undertaken in partnership with the regional health authority, was assisted and encouraged through the creation of a new legal framework that specified the partnership’s goals and terms, and established how the practice would become part of a patient-focused network. Compensation was addressed as a result of the new practice models developed.

In the Calgary Health Region, Primary Care Initiative develops formal partnerships between groups of family physicians and the local health region. The goal is to have 80% of family medicine practices connected through information technology with the region and 30% of family physicians participating in shared care.

**Three Priorities**
Family physicians and the regional authority agreed that the networks of family medicine practices would focus on three priorities: shared care, access to episodic care without an appointment, and the flow of information.

- Shared care refers to various types of relationships and support: between general practitioners and specialists, between general practitioners and other caregivers, and between the health care team and patients. The goal is to supply as much care as possible near the patient’s community, and, by supplying them with the information they need, improve their ability to care for themselves.

- Access to episodic care without an appointment is provided in part through a triage telephone service (24/7) set up as an integrated part of the medical practice. Family physicians provide support (such as consultations over the phone and quick scheduling of appointments). A clinic is also being planned; it will be operated by local family physicians and will supply some diagnostic, laboratory and technical services. The goal is to support both access to care in the community and the family physician’s ability to provide it.

- Quick and safe access to relevant patient information is an essential part of a network based on medical practice and shared care.
Quebec’s Family Medicine Groups

In Quebec, it was decided that the primary care network would be the foundation of the health care system. A new institution, the Family Medicine Group (FMG), would become the main actor providing medical services as part of local primary care delivery.

The FMG negotiates agreements with its local community clinic (CLSC), the agency responsible for delivery of front line social services, in order to provide a complete range of services and ensure it is fully integrated into the primary care network.

In addition to agreements signed with its local CLSC, the FMG can negotiate collaboration agreements with other professionals, organizations, or institutions in the health and social services network.

The implementation of FMGs began in 2001. The government chose not to go through a pilot project phase. During a limited start-up period, it will support the training and implementation of an initial core group of 20 FMGs. Adjustments will then be made to the model before it is applied on a wider basis. The objective is for 80% of family physicians to join FMGs, although individual physicians will remain free to practice privately.

The FMG is a group of family physicians from different communities who, in collaboration with nurses and other health care professionals, have chosen to work together, supplying a range of primary care medical services 24/7. A FMG is responsible for a given territory and provides health care to a clientele that has freely registered to receive its services.

- The degree of co-ordination and intensity of collaboration in a FMG can vary widely, going from people who work together in the same office to a network of individuals providing each other support as required.
- FMGs will also fall within the health services organization plan developed by regional governmental authorities responsible for managing health care and social services.

Australia’s Divisions of General Practice

Several of the objectives set as part of Australian reforms to primary care services were similar to those identified in Canada, although the Australian model also included a particular focus on improving health in rural areas and providing more advanced training to family physicians. To attain these objectives, Divisions of General Practice were created, effectively organizing the general physicians of a specific area into large groups. The Division is in fact a network linking general physicians among themselves as well as to hospitals, the government, health care organizations and their local community.

- The average division has 142 general physicians, but this may vary from 12 to 700. Each division serves an average of 130,000 people, with a population base as high as 600,000.

- A division provides neither clinical services nor the financial management of medical practices. The role they play with respect to family physicians is similar to that played by a hospital department in the practice of specialists working there.

- Divisions are essentially involved in managing various health care programs (for example, mental health or diabetes) and health promotion, liaising with hospitals, and supplying specific services (such as
training) to its family physician members. In the final analysis, divisions are paid for their involvement in the process of defining and responding to community needs.

The terms of compensation have been set in such a way as to create financial incentives for practising quality medicine.

- The amounts granted will vary as a function of factors such as offering services after business hours or in rural areas, planning long-term patient care, using computer systems for prescriptions, the type of accreditation, or the number of internships offered to students.

- The funding formula includes additional compensation for specific tasks: conducting annual evaluations of elderly or Aboriginal patients, preparing multidisciplinary plans for some types of clientele, and holding case conferences.

- Financial incentives are offered for the immunization of patients.

- Financial and technical support is provided for the implementation of computer systems.

The advantages and disadvantages of the Australian reform

According to Grant Russell, Australia did not have the understaffing problem we have in Canada, so reform dealt more with improving quality of care and the training of family physicians. As a result, family physicians in Australia are now more highly trained and better integrated into the health care system, and they play a broader role in health care delivery. On the other hand, the increase in paperwork has had an effect on morale.

It would appear that the general opinion about reform in Australia is that it has veered off track. Reforms began in the field with the funding of very diverse and interesting initiatives involving groups of family physicians and new forms of practice. More recently, a top-down approach with greater emphasis on control has been implemented, resulting in the disappearance of most of the local initiatives. The Divisions, originally designed to integrate and support one-on-one, physician-to-patient practice, now seem to give more emphasis to public health objectives.

◆ Many points in common

Local reforms being implemented in Ontario, Alberta and Quebec have similar objectives:

- All reforms put family physician groups at the heart of primary care services. These groups are based in a given territory, and their member physicians share responsibility for delivering services to a clientele that has registered with their network or group.

- The aim of reforms is to have member physicians working closely with other health professionals (in particular, nurses) as part of their practice, and developing a multidisciplinary approach to patient care.

- Adjustments or changes have had to be made to physicians’ terms of compensation so that they would be more in line with this new approach to practice.

- Reforms have been based on the free participation of family physicians and other professionals in this new approach to organizing medical practice. All three provinces have created financial incentives to encourage this participation.
Although they involve the voluntary participation of patients in a group, they require that patients make certain commitments.

They insist on the fundamental importance of these groups, and primary care services in general, taking advantage of a powerful information and communications system.

... and some differences
There are differences in each province’s strategy for implementing these reforms.

Ontario gave responsibility for coordinating the implementation of its reform to an independent, centralized agency. In Quebec, this role was given to a group of experts supported by the Department of Health. Alberta preferred to have this function performed by regional health authorities. A central agency is considered valuable if it focuses exclusively on implementation and is able to act relatively independently of the government. It has been noted, however, that without regional authorities, reforms cannot be implemented as quickly.

Ontario and Alberta tested the reform in pilot projects, while Quebec moved quickly to set up an initial series of physician groups.

Ontario supported the implementation of its reform with a much larger financial investment than either Quebec or Alberta.

◆ Obstacles

☑ Different perspectives, contradictory messages, conflicting timetables
There are two different perspectives on reform, and they seem to create conflict more often than they complement each other. There is the perspective of political authorities and that of physicians and other professionals; in other words, how planners and decision makers view the reform versus the perspective of someone working in the field.

- The State, operating under a complex political and administrative process and a rigid annual budgetary framework, does not always have the flexibility required for quick decision making or approvals of the investments required.

- There is a lack of consistency and follow-through in the different phases of reform (for example, pilot projects of all kinds funded by several organizations, demonstration projects, generalization). What is communicated in one phase may contradict what is said in another. During the pilot project phase, a variety of initiatives adapted to local or regional needs are encouraged, but when the reform is being implemented on a wider basis, authorities fall back on top-down approaches characterized by uniformity and above all, the need to exercise control.

As a result, there is a general lack of co-ordination between actors, because political authorities dictate an agenda and impose a timeframe that are not always in synch with the usual phases of reform implementation and approval. Political and managerial authorities take a certain amount of time to arrive
at decisions, but once a decision is made, they expect it to be implemented very quickly, even if it means skipping or rushing through the steps required in approving any complex change.

☑ Resistance in the field
Various types of resistance are also encountered in the field:

- There is distrust and opposition on the part of some members of the medical profession, who have become sceptical or cynical regarding the government’s intentions.

- There is resistance due to the culture and styles of practice found in urban areas, because the patients and family physicians there are accustomed to relatively quick access to specialists and are not always ready to change their habits and adopt a more intensive use of primary care resources.

- There are problems of perception when the reform of primary care services is part of a range of other projects that are perceived as being in competition with each other, when they are, in fact, complementary.

- Disinformation and rumours accompany the implementation of any new project, interfering with how well it can be understood.

Fear of Organizing
According to Jean-Louis Denis, the medical profession would appear to have discovered that they need to reconsider how they organize their practice. This may have come as a surprise since the need for change emerged from shifts in the profession itself and its conditions of practice. A variety of factors are behind this impetus for change, including the evolution of the nursing profession, technical capacities or the type of care required. As a result, medical practice as it was known a few decades ago is disappearing (individuals enjoying high-profile professional and social status who work with little in the way of technical support or support staff). All indications are that the pressure exerted by these changes will only become more acute over time.

To meet this challenge, the physicians need organizations that are appropriate to their practice, whatever form these may take. Medical professionals often perceive organizations as restrictions on their freedom, imposed by bureaucrats and aimed at limiting how they can practice. In contrast, the quality of their practice and their ability to apply their expertise is becoming more and more dependent on the support of an organizational structure that can manage a range of resources and different kinds of expertise. Organizations have become essential for maintaining a medical practice of real quality; without them, the conditions of practice can only deteriorate, and the profession will suffer as resources fall progressively shorter of its needs.

☑ A financial, legal and regulatory framework that is incongruent with the objectives of reform
The obstacles discussed above are related first and foremost to a clash of cultures and habits. Another important hurdle is the inflexibility of the administrative, legal and regulatory framework.

- Methods of compensating family physicians practising in clinics or private practice are not adapted to new situations or the new models of practice being proposed. Fee-for-service methods do not appear to be compatible with prevention and health promotion activities, a comprehensive and integrated approach to services, or the type of collaborative practice sought in primary care delivery.
• The legal and regulatory framework, particularly as it governs the responsibilities held by each of the professions, represents more of a hindrance to getting professionals to collaborate than the source of leverage it should be.

**Success is a shared responsibility**

Participants at the Colloquium mentioned several factors that can play a role in the successful implementation of reforms; indeed, reveal the conditions required. They include the means or strategies required to confront any obstacles that may arise. Their implementation can be seen as a challenge that must be met by all the actors involved in reform: the central government, authorities charged with planning and organizing services in a given region, professional organizations and unions, locally based professional groups, and the professionals working in the system.

Creating these conditions may be the responsibility of a single actor, but more often than not, the responsibility is shared among several of the actors involved in the reform.

**THE RESPONSIBILITIES OF GOVERNMENTAL AND PROFESSIONAL AUTHORITIES**

► **Clear and firm leadership, but an appropriate and flexible implementation strategy**

Some of the projects for reforming primary care services have been in the works for decades without producing much in the way of convincing results. It is therefore time to act. To do so, however, we must acknowledge that changes in technology and the professions require that we restructure in a significant way. Colloquium participants believe that a wide consensus exists on the need for reform and the directions that have been taken. We need to seize this opportunity and act in concert with those who share the conviction that the agenda needs to move forward.

• Given this context, it is up to the government to propose a comprehensive vision of the health care system it wants to implement, promote this vision among the actors concerned and the general public, set out clear directions for this reform and, above all, demonstrate a clear and firm political will to have it implemented and support this process.

At this point, however, this clear vision must be flexible enough to not dictate how anyone in the field should act. As much as the government must exercise a firm will regarding the fundamentals of reform, it must also demonstrate flexibility and patience throughout the implementation process. Change must be seen as an evolutionary process that recognizes what has been achieved in family medicine and uses it as a stepping stone to accomplishing the work that remains.

• The authority responsible for managing the health care system in any given region should be able to adapt the general directions set for reform, the selected implementation strategies, and any incentive or support measures so that they are appropriate to the local context.
• Above all, front-line actors should have the freedom to choose their own means, define their margins of manoeuvre, and set timeframes for adopting the new mission and rules of the game.

More specifically, successful reform will be more likely if implementation involves:

• Trying various flexible approaches that reflect the diversity of the people, situations and regions involved;

• Creating win-win situations in which the parties have taken the time to understand each other’s specific situations, needs, and expectations, building confidence in each other and working together to find solutions that respond to these needs and expectations;

• Explaining the reasons behind the reform and addressing perceptions and fears as a way of attenuating distrust and disinformation;

• Sharing the vision underlying reform with the public at large and, where possible, encouraging its involvement in implementation strategies.

☞ Adjusting the legal, regulatory and professional framework

• The State, professional regulatory bodies and unions must agree on new legal measures or regulations that would provide a better framework for the new forms of group practice and, more specifically, would specify areas of accountability.

• A new professional culture must be developed and the legal framework of professional practice must be adjusted in such a way as to take into account new styles of practice, experiments in sharing professional acts, and unprecedented collaborative relationships between the various professions and between primary care and specialized care.

☞ Adjusting methods of compensation

• Negotiations are needed to establish a new method for compensating physicians. It will take into account the new conditions of practice (being part of a group practice, interdisciplinarity) and the new professional activities required in a family medicine group. It must be an incentive, encouraging family physicians to join a group practice.

• The administrative tasks involved in group practice, the co-ordination of professionals and services, and the points where service lines meet must be simplified.

☞ Financial and organizational support

• The investment in reform must not only cover

A new level between strategists and clinicians for consensus building

According to Claudine Archambault, one of the problems encountered in the various experiments involving integrating or co-ordinating services is how to ensure that family physicians participate in the new system. In the Bois-Francs region, they confronted this problem by having the general practitioners set directions for and co-ordinate primary care services for the elderly (a mediating role). A “Territorial Medical Committee,” made up of a dozen general practitioners from a variety of practices, played a pivotal role; it exercised influence on both the consensus-building process (among representatives from organizations in the regional network) and clinical activities (as carried out by teams of case managers co-ordinating services provided to individuals).
its implementation and costs specific to the transition period, but also include incentives to encourage physicians to take part.

- Practical support will be needed (resource persons, consultants) to assist those undertaking the establishment and implementation of new organizational and managerial methods in professional groups.

This experience can inspire other initiatives to reform primary care. One can see how a mediating role could also be played by family physicians (and other professionals or members of the research community) in consensus-building between administrative authorities involved in planning or co-ordination and the work of clinical teams (such as Family Medicine Groups). Among other things, such a group could also serve as a forum where investigators and clinicians share their experience in research and clinical practice as well as develop practical solutions to accessibility, continuity of service and service quality problems.

**Implementation of a powerful information and communications system**

Primary care service organizations must quickly acquire integrated information systems and effective means of communication to provide professionals with rapid access to relevant clinical data (such as real-time delivery of evaluation, consultation and examination reports and shared clinical files), various support services (diagnostic or laboratory services) or different types of expertise. The implementation of such a system would allow primary care professionals to provide patient care themselves without redirecting cases to an emergency department or specialist.

**THE PHYSICIAN’S RESPONSIBILITIES IN GROUP PRACTICE**

It is clear that several of the conditions for succeeding at reform can be implemented in family medicine groups and networks, which are at the leading edge of any reform in primary care delivery. In particular, changes can be made in methods of compensation, or in the support provided for the implementation of a powerful communications network. Other conditions, however, depend more directly on how group practices function.

- **A mission in common**

  Members of a group practice must subscribe to a clear mission and set common objectives. For example, the group as a whole must take the time to decide how its members will provide care to vulnerable patients, such as persons with a mental illness or otherwise incapacitated.

- **A basket of services**

  The group must define a basket of services that is adapted to the specific needs of its clientele and the population it serves (for example, these decisions can be based on public health studies).

- **Strategic planning**

  The group must undertake a strategic planning process in order to realize its mission and attain its objectives. The resulting plan will set deadlines for each step of the process and determine mechanisms for evaluating the attainment of objectives.

- **Specific responsibilities**

  There must be a clear definition of responsibilities held by the group as a whole, by each discipline, core members.

  According to *Serge Dulude*, in order to be
effective, a group of family physicians must be able to count on a “core” of family physicians who exercise most of their case management and follow-up activities within the group. This can be expressed as “the two-thirds rule:” at least two thirds of member physicians must practice principally within the group, and two thirds of these clinical activities must consist of case management and follow-up. This rule does not rule out calling on other physicians to act as replacements or offering consultations without appointment, but it clearly underscores the importance of having a consistent group of family physicians who take responsibility for and manage ongoing care for a regular clientele, patients they know well.

Beyond the creation of structures, the need to change attitudes

According Jean-Guy Émond, to create family medicine groups is in fact to introduce a new element into the overall health care system. This structural change requires a major change in organizational culture. This immediately affects physicians, of course, who must learn to collaborate more closely with each other and with other professionals. It also affects all the institutions in the system, which, because of the presence of this new player in primary care, must reposition themselves in the system. Finally, it effects the patients themselves, particularly those in urban areas, who must develop the reflex to consult these new primary services before going elsewhere.

For other conditions of success (related to collaboration between members of the various professions and disciplines), see page 29.
2. SHARING CLINICAL RESPONSIBILITIES

A collaboration that requires all actors to take new positions on the professional chessboard

Professional collaboration is not only an opportunity to provide patients with better and more complete services than could be delivered by each professional acting independently, it also gives professionals a chance to learn from each other. The advantages of collaboration are therefore threefold: more client participation in service delivery, better service integration, and a stimulating work environment for professional caregivers.

a) Redefining and specifying roles
The transformation of primary care services creates a system with family medicine teams composed of different types of professionals working in collaborative relationships and interdisciplinary settings. Professionals will have to re-examine and redefine their roles, and this process will begin with changed roles for family physicians and nurses. How will their new responsibilities as team members be defined? Will a common clinical approach be required among these team members? What types of collaboration will need to be established?

The family physician looks for a new direction
More and more, family physicians will find themselves called upon to work in teams, both with other physicians and with other professionals (including, first and foremost, nurses). Collaborative practice will have significant repercussions on family medicine; some of these have been mentioned above, and others will be described below. At this writing, it would appear that the challenge to the status quo goes far beyond these new approaches to practice.

The problem of understaffing does not in itself explain the disarray in parts of the profession today. In family medicine, the problem is also rooted in not knowing what roles physicians should be training for and, consequently, how to go about training them for those roles. Some family physicians, in particular the youngest ones or those in training, wonder what society expects from them; they wonder what the public needs. Various messages seem to be coming at them from all sides, and these messages are difficult to interpret.

It does not appear that the medical profession’s traditional “territorial” approach will provide appropriate answers to these questions. This time, the role played by other professionals must be taken into account. The role of other professionals, however, will not threaten that of the physician, but will in fact reinforce it.
Primary care medicine, perhaps, but what kind of primary care medicine?

According to Yannick Villedieu, the public’s basic expectations of primary care services appear to be quite simple: they want personalized services (my doctor, my clinic, my health care team), and they do not want to be treated like numbers. They also want full-time access and reasonable waiting periods.

In order to meet these expectations, primary care services cannot only deliver curative or conventional clinical medicine, since this is neither the only nor the best response to the important public health issues of the day (including obesity, drug dependencies and mental health). What is needed is front-line medicine; medicine that takes a more comprehensive approach to the individual’s health care problems.

Furthermore, it is not enough to staff this front line only with physicians. Family physicians are required, but other professionals are also needed, starting with primary care nurses and pharmacists and including psychologists, social workers, nutritionists, educators, rehabilitation specialists, and visiting homemakers.

Primary care nursing: a practical definition has yet to be found

We are facing a shortage of family physicians, an ageing population, and entire communities without access to primary care services. It is clear that, if the system is to meet these needs, it must have enough nurses with the appropriate training to complete the tasks required. But the role of the nurse trained specifically for primary care is still not properly defined, is poorly understood, and is perceived in a variety of ways. Drawing on experience in Ontario (the Nurse Practitioner), the United Kingdom (the Practice Nurse) and Quebec, participants at the Colloquium set out to define this role.

IN ONTARIO, nurse practitioners could play a larger role in primary care.

The profession of Nurse Practitioner is already well established in the 50 American states, Australia and New Zealand. In Canada, however, it is relatively new. In some provinces, nurse practitioners are already practising; in others, bills are being considered or tabled to allow this type of practice.

- In Ontario, nurse practitioners have a long history dating back to the 1970s and were the subject of the first randomized controlled trial of primary care NPs (Spitzer et al. The Burlington Randomized Trial of the Nurse Practitioner. NEJM 1974;290:251-6). Educational programs initiated in Ontario in the 1970s to prepare NPs were discontinued in 1983 due to the surplus of family physicians, the absence of appropriate remunerative mechanisms for NPs, and an attitudinal barrier on the part of some physicians.

- In 1994, the Minister of Health announced a plan for the ongoing education and employment of NPs as equal partners in multidisciplinary health care teams; in 1995, a common educational program for NPs at the baccalaureate level was initiated in all 10 Faculties/Schools of Nursing in Ontario. On passing their certification exams, the College of Nurses of Ontario designates these nurses as RN (EC)s (extended class). RN(EC)s have legal recognition to diagnose and treat common diseases within their scope of practice and the College of Nurses of Ontario has developed standards of practice for this NP role.
RN(EC)s carry their own malpractice insurance and are solely liable for their actions when they see a patient.

The nurse practitioner in primary care can be defined as a registered nurse with advanced competencies gained through additional education and practice that enables the NP to provide health education and health promotion; deliver preventative and wellness care; diagnose and treat minor acute illnesses and injuries; and monitor stable chronic diseases.

- In spite of the independence implicit in this role, nurse practitioners usually work in a multidisciplinary team where their specific contribution mainly involves prevention and health promotion activities, but can also include diagnosing and treating benign illnesses and minor injuries and following up on stable, chronic illnesses.

- Nurse practitioners can prescribe some types of medication for common illnesses and some types of ultrasound, X-ray and laboratory tests.

A role that needs to be defined more clearly
In spite of the manifest need for nurse practitioners and the studies that have shown how their contributions can improve quality of care, this role has not yet been fully realized in primary care.

- The nurse practitioner’s contribution in a service team is still often consultative (with the physician making the decisions), whereas the professional role should be based on a truly collaborative relationship.

- There are nurse practitioners trained in the profession who are not working in this capacity. The main reasons given for this situation are:
  - the required positions are not adequately funded;
  - current methods of compensating physicians work against the integration of nurse practitioners into a collaborative practice of primary health care delivery;
  - there is no consensus about service delivery models that facilitate collaborative practice;
  - the true potential of the role is poorly understood.
  - some physicians continue to worry about liability issues

There was a fear that quality of care would suffer, but the opposite is true.

According to Alba DiCenso, a systematic review of 11 randomized controlled trials conducted internationally (Horrocks et al, BMJ 2002) revealed that the introduction of nurse practitioners did not result in a deterioration of patient health, as some feared. The number of prescriptions, return visits, or referrals to a physician did not increase, either. Some studies indicated that nurse practitioners ordered more tests than physicians, and spent more time with patients. Finally, some of the services provided by nurse practitioners were considered of better quality than those given by physicians, and these services engendered a higher level of satisfaction among patients.

According to Alba DiCenso, however, these evaluations were not entirely on the mark. Comparisons were made between the performance of a nurse practitioner and that of a physician, whereas the role is basically intended to be implemented within an interdisciplinary team where nurse practitioners collaborate with physicians. It is therefore the performance of this collaborative practice that should be compared with a medical practice where the role does not exist.
IN THE UNITED KINGDOM,
the role of “Practice Nurse” in primary care has been expanded,
and has become more specialized and independent.
The role of “Practice Nurse” has evolved a great deal over the last 20 years. While nurses had often acted as assistants to family physicians, limited to “putting on band-aids,” they have now become full collaborators, even when they are working as the physician’s employees.

- In some instances, practice nurses have become specialized in specific areas of care (such as diabetes and cardiovascular illnesses) and are responsible for their own cases. Often the patients choose their nurse.

- Practice nurses will soon have the right to prescribe medication, as a physician does, in the context of specific, well-defined situations. This legal change will only endorse an existing practice, since nurses already recommend treatment, albeit in a more informal manner.

One of the factors that has worked in favour of the practice nurse role has been the presence of Health Care Assistants, professionals often trained on the job, in health care teams. The assistants carry out tasks that were formerly done by nurses, so nurses have been freed to play a more specialized role.

The development of this new role for British nurses has resulted in changes to other professions.

According to Peter Weaving and Gillian Ridley, the evolution of the nursing profession toward more responsibility and independence was made possible by legislative changes, but the change occurred very gradually in the workplace. The willingness of nurses to become more professional and develop more specialized skills played a key role in the process. It was often the nurses who questioned their own roles and the traditional roles of other professionals, including physicians and assistants.

Challenging the status quo in this way was worthwhile because it was part of a larger movement to improve the roles played by each of the professions. In fact, the new division of tasks made the work of all three professions more interesting and rewarding. Family physicians, in particular, found that, once they were freed of certain tasks, they could work more independently and develop new areas of practice that were more specialized or complex. Another result of these changes was that patients spent less time on waiting lists.

IN QUÉBEC,
a working definition of Nurse Practitioner in a Specialized Area, a practice that has only recently been recognized, is being developed in tertiary care.

A law recently passed in Quebec has made changes to nine health care professions, including the legal recognition of specialized nursing practice. This type of practice already existed, in particular in tertiary care services offered in hospitals, but had not been legally recognized and did not have a specific professional status or salary level.

The law specifies five activities that are part of the definition of a medical procedure, but that can now, under certain conditions, be exercised by nursing specialists, who can add them to their current scope of practice:

Primary care intervention: a role custom-made for nurses

According to Édith Côté, primary care nurses are above all professionals. Like all professionals, they must be able to solve problems, i.e. identify and evaluate them, find an...
• the prescription of diagnostic examinations,
• the use of diagnostic techniques that are invasive or present a risk of harm,
• the prescription of medication or other substances,
• the prescription of medical treatments,
• the use of techniques or the application of medical treatments that are invasive or present a risk of harm.

Quebec universities are currently developing a training program for advanced nursing practice in tertiary care. The areas given highest priority are cardiology, nephrology and neonatology.

The new legal instruments have until this time only been used to develop specialized nursing practice in tertiary care, but nothing prevents them from being as useful in developing this nursing practice in a primary care setting.

b) A collaboration that still raises questions and provokes comments

There seems to be a consensus about the need for nurses in the development of primary care services. But the kind of contribution they can make and, more generally, the type of collaboration needed between nurses and family physicians, still begs certain questions.

☑. Are methods of compensation and the regulatory framework limiting the development of this type of collaboration?

Many legal, regulatory and administrative obstacles still appear to be hampering attempts to establish truly collaborative working relationships in primary care and the integration of nurse practitioners into family medicine teams.

• Current practices in compensating physicians do not adequately cover administrative costs related to the work of nurses and the time required for consultations between nurses and physicians.

• Family physicians still appear to be concerned about the issues of responsibility and accountability in the context of a collaborative practice. How, for example, can the nurse practitioner’s status as an appropriate response, decide how to proceed, and ensure follow-up care and an appropriate evaluation of the results. This process is fundamental to activities such as the first contact with a patient, triage, health promotion and prevention, follow-up and referral to other professionals or services as required.

The terms “identify” and “evaluate” are used instead of “diagnose,” as diagnosis is a reserved medical procedure. Responsibility for the diagnosis of a health problem remains an issue in Quebec. This may explain why specialized nursing practice has begun in tertiary care, where the diagnosis has already been made, but is slow to become established in primary care, where often this is not the case.

Furthermore, from what can be determined at this time, the implementation of Family Medicine Groups does not guarantee that nursing specialists will find a place in primary care. The situation is not simply that a new professional partner would be integrated into an existing system or a given practice; it is rather that the very system or practice itself is being transformed. This transformation is very complex, and the role of primary care nurse is only one element in a much larger picture. This element has nevertheless received specific mention in the Clair Commission report.

Nurses should soon find an appropriate role in primary care, however, since the one they will be given corresponds directly to fundamental aspects of their training and profession.
employee be reconciled with the professional independence the role requires? In the case where a nurse is a physician’s employee, how can this status be reconciled with the status implied by a professional collaboration?

☑ Is there a risk that care will be compartmentalized or fragmented, or that quality of care will suffer?
Some observers believe that there are inherent risks in family physicians sharing tasks with other professionals, team members becoming more specialized to deal with some problems, and nurses acquiring greater professional independence.

• One such risk would be greater compartmentalization of care and the kind of fragmentation of care for which specialists are often criticized. Such a trend would run against the essence of family medicine: a holistic approach to patient care.

It is understood that, while the increasing complexity of medical issues is making the practice of generalist medicine more difficult to realize and therefore demands team-based practice, doubts remain as to whether the entire team will be able to provide the comprehensive approach required in patient care.

It is important that one member of the team continues to play this role, overseeing and integrating patient care, while working in collaboration with other team members.

• Furthermore, given that the shortage of family physicians is one of the realities underlying reform initiatives, participants also wondered if giving nurses a larger role in primary care services might create a kind of “low-cost physician.”

☑ Will reforms result in a more holistic approach, better access to physicians and better use of professional resources?
Other participants did not share the negative view just stated, seeing clear advantages to the sharing of clinical tasks.

• The holistic approach that is so integral to the practice of family medicine has become too difficult and complex to be carried by one person. On the other hand, a close working relationship between a nurse and a physician can provide the same holistic approach to a clinical situation, particularly if the patient can choose which professional will deal with the problem. Collaborative practice has existed for some time in fields other than general medicine (for example, in the treatment of diabetes or in mental health), and patients are more and more accustomed to dealing with teams of professionals; indeed, they enjoy having a team at their service.

Learning to take advantage of what the other has to offer

According to June Bergman, an ongoing experiment in Calgary is providing interesting data on working relationships between nurses and family physicians. The project has put nurses in charge of home support services and has them working in partnership with family physicians. The goal was to solve service access and continuity problems resulting from the fact that a nurse’s caseload was not tied to any given physician. In fact, the 40, 50 or 60 persons receiving home support from any given nurse...
It is expected that the larger role assumed by nurses will have immediate and positive effects on patient access to the family physician. If nurses or other health care professionals carry some of the physician’s current tasks out independently, the physician will be able to invest more time in his or her clientele.

Instead of perceiving collaboration between physicians and nurses as something that the two professions must come to grips with, it could be perceived as a stimulating opportunity for the two professions to work together in addressing more complex health problems requiring a sustained and comprehensive approach to care. Both of these professions are understaffed; collaboration will give them an opportunity to use all the resources of their respective fields in the service of patients, resources that have not been used to their full potential in the past.

The evaluation of the experiment revealed a high degree of satisfaction among all parties—nurses, physicians and patients—in addition to reduced use of emergency services and no increase in system costs. Professionals on each side quickly realized that they had something to gain from what the other had to offer. Each side recognized the family physician’s expertise in diagnosis and treatment, and the home care nurse’s corresponding abilities in case management and community relations. The partnership was built on their respective abilities and the reciprocal benefits.

**Professional insecurity creates resistance to change**

According to Jean-Louis Denis, all health care professionals, including both nurses and physicians, tend to feel a bit insecure when faced with the prospect of change. We could try to reassure them by pointing out that there is enough work for everyone, but professional insecurity will remain a fundamental issue in the implementation of changes, and it must be addressed.

In order for members of a profession to feel confident enough to collaborate with other professionals and invest in a process of change, roles must be well defined, the contributions of each profession must be understood, and individuals must know what is expected of them.

Imminent changes in health care systems, and in particular, collaboration between the professions, will require that professional bodies reflect on these issues and consider the future of their practice. Nurses have already begun this process. Physicians, on the other hand, have perhaps had less opportunity to venture into this area, because, until recently, they have not been put in situations that challenged their notions of where the profession was going. It would now appear that the medical profession, in particular family medicine, confronted with a series of factors such as changes in technology and the other professions, has arrived at a turning point. Physicians are now obliged to ask some hard questions about how the specificity of their profession can be maintained, and about its future.
c) Conditions for effective collaboration

Be it in official Colloquium presentations or more casually in workshop exchanges, ideas emerged concerning the nature of working partnerships between physicians and nurses. At times there was a consensus on these issues; at other times, they revealed different approaches.

⇒ An explicit relationship of trust

There was widespread agreement that a working partnership between a physician and a nurse—and, more generally, between all the professionals in the team—must be based on a relationship of trust, and that this trust must be explicit and apparent to patients. For example, in a relationship of trust, the physician will direct patients to the nurse, the two will work together in dealing with the case, and it will be clear to the patient that this is what is happening.

- In order to build this trust, each professional must respect the knowledge and abilities of the other, the capacity of each to make informed decisions in the best interests of the patient. This notion often runs counter to the profession-specific training they received.

- Decisions must be planned and made together. This assumes that they will take account of different points of view and of concerns expressed by the different professionals involved. Members of the team must also share responsibility for decisions once they have been made and work together in their implementation.

- Communication between professionals must be frank and transparent.

⇒ Does the physician carry the responsibility or is it shared?

On the other hand, various exchanges among the participants brought out two different points of view concerning who bears professional responsibilities.

- Some participants thought that the physician must maintain a privileged link with patients and the responsibility for diagnosis and treatment that follows.
  This position did provoke several reactions, however, as some participants found it a bit arrogant to maintain that the physician is the only professional to maintain a privileged relationship with a patient, a unique relationship that other health care professionals would be unable to establish.

- Other participants thought that the physician and nurse should work together in patient follow-up and share evaluation, diagnosis and treatment responsibilities according to their respective expertise.
  Under this vision, nurses are seen as partners to the extent that their expertise can be brought to the working relationship and the services delivered to patients. Examples provided of this expertise included links with community resources, the education of some types of patient, and, in the case of some types of chronic illnesses, patient follow-up.
Focusing on what is at stake

To resolve the problems of working in teams, the focus must constantly be brought back to what is best for patient health and our common purpose: ensuring more effective service delivery and better service quality.

Discussions about collaborative working relationships, even in actual cases, often lead to abstractions. In fact, experience and research has shown that this style of organizing work is most effective when it focuses on the task at hand. Effective collaboration always begins with two questions: why are we collaborating, and what problem needs to be resolved? These questions need to be addressed before the partnership’s specific processes and means—the “who does what” and the “how”—can be settled.

A clear division of “who does what”

Professionals working in teams inevitably find themselves in situations where their expertise and abilities overlap or could be handled by more than one member. To avoid this duplication and ensure continuity of service, the team must establish clear rules for determining who does what by addressing the following questions:
- What needs to be done?
- Who has the relevant knowledge and know-how?
- Who has the power to get it done?
- Who prefers doing it?
- Who does the patient want to see?
- Who is available?
- Who will lead?
- Who will provide support?

Mechanisms to support teamwork

Professionals working in a team must have the support of effective mechanisms:

- mechanisms for formal or informal consultation,
- referral mechanisms,
- transferral mechanisms,
- the delegation of medical procedures,
- practice guidelines (founded on evidence-based practices and applying to the whole team) that provide consistency in clinical practices.

Standards for multidisciplinary practice

In addition to rules supporting co-operation, the team also needs general and multidisciplinary standards governing teamwork (care or service protocols) that take each professional’s role into account. These standards help avoid excessive variations in practice among different team members.

When good will is not enough

According to Daniel Way and Linda Jones, true collaboration among professionals will not occur if it is only based on good will or the “chemistry” that may develop between them. These factors are important, but will only last for a limited time if they are not supported by structured ways of collaborating. Based on their experience and research, Way and Jones have developed a structured model of collaborative practice for family physicians and nurses (Way & Jones, 1994, 2001). The model also applies to the contributions of other professionals in a multidisciplinary team.

This structured collaborative practice is based on a holistic approach that puts the client at the centre of service delivery. It makes the client a partner in the service delivery process; someone the professionals know. Under this model, collaborative relationships are built on recognition of and respect.
Procedural models adapted to collaborative relationships

New models must also be developed for collaborative practice. They must be adapted to the specific requirements of collaborative working relationships and the various situations that can be encountered in clinical practice. (For example, allowing nurses to send patients directly to specialists without conferring with a family physician, and, consequently, allowing the specialist to bill for this consultation.)

Professional accreditation that recognizes work experience

The accreditation of nurse practitioners or nursing specialists should not be exclusively based on their level of education, but should also recognize the expertise and competencies acquired in the workplace.

Research on collaboration

Research should focus on the effectiveness of collaborative practice rather than how the roles of physicians and other professionals differ from one another.

Regional research and training centres should be established to concentrate on interdisciplinary services in primary care.

Interdisciplinary training

There is a need for interdisciplinary training programs focused on collaborative practice for residents in family medicine, nurses and pharmacy students.

Training programs for physicians and nurses differ in fundamental ways. As a result, their approach to professional practice comes out of two distinct views of health, two different cultures that effect how they respond to a health problem and how they deal with patients. Moreover, this profession-specific training sometimes instills reservations about the roles played for the integrity of both professions: both the physician and nurse continue practising their respective professions. It therefore makes effective use of not only the knowledge and know-how of each individual profession, but also the knowledge and know-how that is shared between these two professions. It is the resulting synergy that allows the team to offer a global response that exceeds what they could offer if acting individually.

In fact, this model of collaborative practice takes varying degrees of collaboration into account, according to the type of activity:

- activities in which each professional continues their own practice independently of but alongside other professionals;
- activities in which the family physician supports the nurse practitioner through consultations and referrals;
- activities in which both professionals engage in an interdependent practice by providing services together, making decisions synergistically and supplying mutual consultations and referrals.

Maintain your identity, but always put yourself in the other person’s shoes

According to Vania Jiménez-Sigouin, interdisciplinary work involves two people from different cultures. We can therefore speak of this work as founded in a context of true “intercultural relations.” The three movements of intercultural relations therefore would also be applicable to relations between professional cultures:

- Concentrate on the self. I must first know who I am. To collaborate effectively, the physician and nurse do not have to abandon their professional identity; on the contrary, it is important that the physician remain a physician, and the nurse, a nurse. Each profession has its own culture, approach to problems, and language, and must hold on to them.

- Put the self aside and concentrate on the other. Once I know who I am, I must get to know who I am working with. I must make an effort to understand the other person’s culture, approach, and language.
by other disciplines. To some extent, the problems we are experiencing today have resulted from not being able to provide society with the plus value of interdisciplinary training in the various health care disciplines.

- **Negotiation between the two visions.** Without denying the importance of one’s own culture or that of another member of the team, all parties must seek compromises or areas of agreement. This is the common space, the interdisciplinary space.

This interdisciplinary space is not a juxtaposition of cultures and languages, but a space where professionals can find other meanings that are beyond what is specific to their own professions. One can never reach this interdisciplinary space, this “common meaning,” in any definitive way. Since each profession operates with its own dynamic, team members must constantly engage in this triple movement of concentration on the self, on the other team member, and negotiation between the two.
3. MANAGING CHANGE

*Listen to those who will be living through the changes*

Participants shared many thoughts on strategies used in introducing, extending or implementing changes. Two participants addressed this subject more specifically.

According to *Claude Béland*, organizations change primarily in response to pressure exerted by external forces, such as changes in technology and communications, progress in the biological sciences, the globalization of trade, and the influence of financial markets. Paradoxically, this changing environment does not necessarily assist the organization in its attempts to change. Like anything new and mysterious, changes in the environment provoke corresponding changes in behaviour and values, both in individuals and their communities. This tends to create a narrow focus; avoid risk, save your own skin before thinking about someone else, focus on your own problems. In this way, members of an organization lose their overview of a situation and forget that they need to co-operate and retain a sense of responsibility to others.

**Have a global vision**
The first condition for succeeding at organizational change is therefore to have the organization as a whole adopts a global vision of how society works and its current evolution.

**Know the issues**
That, however, is not enough. The organization must also know *why* it must change, why it must be transformed. All its members must understand the real issues at stake: the risks inherent in change, and the risks in maintaining the status quo.

**Work together to find solutions**
Once all the actors involved have a good understanding of why the organization must change, they must begin working together to find appropriate solutions. In this process, the role of organizational leaders is not to simply provide solutions, but to explain why the change is needed (in terms of environmental changes, organizational issues, perceptions about what is putting the organization’s survival at risk, assessments by experts, etc.). Leadership involves legitimizing the process of change—and the eventual solutions—in the eyes of the actors who will be involved. If not, distrust will take hold, and these actors will begin looking for anything that might confirm their reservations about the process.

It is the members of an organization who have the best understanding of how it works and what kinds of solutions are feasible. It is far more credible to have a problem explained by a colleague and then enter into a discussion about possible solutions than it is to have a manager arrive with a plan for implementing changes.

That being said, organizational changes are not easy to manage, even when these conditions are satisfied, and the process is well underway.
Create advantages for all concerned
Developing an understanding of the issues and providing an opportunity to participate in the process of identifying solutions will clearly ensure complete commitment to the project, but only under one fundamental condition: that all participants see an advantage in the change, that all see an opportunity to improve their quality of life, that all understand that the change is for the better.

Some experts may advise that the proposed or chosen solutions not attempt to satisfy all parties; this notion should be rejected. The opposite is true: solutions should try to satisfy everyone. Avail yourself of all possible means for managing the negative effects of change: for example, replace abolished services with contracts to new companies formed by former employees, provide job search assistance and early retirements, and give priority to rehiring. If solutions are put forward that clearly show respect for each individual’s legitimate aspirations to maintain their quality of life, changes will be easier to implement, even if this requires very detailed planning to deal with the costs involved. If we are prepared to make large investments in technology, we need to be ready to make significant investments in assisting those who are willing to make changes if that will allow them to maintain or improve their quality of life. In short, we need to acknowledge that trying to maintain the quality of life of individual staff members is as legitimate as trying to maintain quality of life of organizational leaders and owners.

Some may think this is just an expensive vision, a utopia, but the cost of resistance to organizational change is always much higher than that of a change made with everyone on board.

Take the initiative to make changes and stay the course
According to Jean-Louis Denis, several pioneering health care projects have shown that professionals who are directly involved in service delivery at the local level are quite capable of exercising leadership. Studies found that, if given the opportunity, the necessary resources and a flexible enough context, front-line actors can take the initiative to propose changes and set them in motion.

A strategy involving local initiatives and small steps in the right direction will not, however, be enough to bring about permanent, widespread change throughout the system. Local initiatives soon run up against limitations that are set at another level and are beyond their control; for example, regulations of professional corporations or unions, the established order for organizing services, or methods of compensation. Professionals in the field must therefore continue to take initiatives at the local level, but they cannot ignore what is happening elsewhere in the system, and they must be sure that their voice is heard when insisting on the right to explore alternative ways of operating.
4. AREAS OF RESEARCH

*Take advantage of a broad experiential base*

The members of the Colloquium’s Scientific Committee have reviewed the many questions raised by participants in the Colloquium of September 19 and 20, and have identified some of the main issues that could be addressed in subsequent studies in order to provide more documentation or answers. Members first undertook this process on an individual basis, and the ideas were then discussed in a group meeting. Several potential areas of research emerged. Some deal with the overall implementation strategy for primary care reform; some concern the organizational means of the systems or groups that have been set up. The third group of ideas concern how health care teams work, with a particular focus on working relationships between professionals.

1. **Implementing, generalizing, and appropriating reform**

The different cases presented at the Colloquium demonstrated a wide variety of strategies used by governments in introducing reforms into their health care systems. Some of the reforms were tested in pilot projects, while others were launched without conducting any experiments beforehand. Reforms are sometimes overseen by a central authority (that could be a governmental department or agency, or a group of experts), and sometimes implementation is put in the hands of regional authorities according to varying types of delegation and degrees of independence. In this respect, the Canadian experience is of particular interest because while reforms had similar objectives, they took distinctly different paths. We should take advantage of this range of experience.

Comparative studies of the various Canadian strategies (with a focus on their similarities and differences) would surely provide assistance in the pursuit of several lines of inquiry.

- Which approach would be the most effective when implementing a reform across a given territory or among all the actors involved?

- How should roles be distributed among central, regional and local authorities in order to encourage a long-term appropriation of changes by actors in the field and ensure the long-term success of the reform?

- What are the main advantages and disadvantages, as perceived by the actors involved in each approach?

2. **Reconciling management objectives and clinical requirements**

Whether the implementation strategy is overseen by a central authority or a regional agency (i.e. a decentralization strategy), it seems there will always be a risk that the ideas of the authority responsible for managing the change will be incongruent with the needs of professionals responsible for turning those ideas into action. Implementation strategies often include a regional or local mechanism that provides an
essential link between system managers and clinicians, but in no case has the effectiveness of this mechanism been evaluated.

- Which of the various forms of co-ordination or liaison best ensures that managerial decision making with respect to a proposed system will receive the required clinical input and, on the other hand, that the clinicians charged with implementing the system will receive adequate managerial support?

- What kind of administrative or organizational support is required by groups of professionals in order to move from individual practice to a collaborative group practice?

### 3. Investigating the environment’s influence on the organizational model adopted by a professional group and the repercussions this choice has on clinical practice and the use of resources

The different types of professional groups created under reforms have essentially the same objectives: better use of available resources, superior continuity of service, a comprehensive approach to patient care, etc. But these groups are implemented in a variety of different socio-cultural, legal, and regulatory contexts that themselves have an effect on the degree of freedom that these professionals can enjoy. Furthermore, the organizational means adopted by one group will have an effect on the type of collaboration that results.

- What *external* factors (such as methods of compensation, professional or union regulations, or the socio-cultural context) will have the greatest influence on how professional groups will organize? How is influence exercised, and what are the main impacts, both positive and negative?

- What *internal* factors (such as available resources, case management, the sharing of clinical responsibilities, etc.) will have the greatest influence on inter-professional or interdisciplinary collaboration and how resources are used? How is this influence exercised, and what are the main impacts, both positive and negative, on the group’s ability to attain its objectives?

- Given all the organizational models at our disposal, which would be the most likely to encourage inter-professional and interdisciplinary collaboration, and which the most likely to make optimal use of resources?

### 4. The plus value of a collaborative practice

A number of contributions made during the Colloquium suggest that collaborative practice is advantageous to both patients and professionals. Some studies agree, even if the relevance of their conclusions has been thrown into doubt by methodological issues. In short, the advantages to be derived from collaborative practice seem based more on subjective perceptions and ideological convictions than any available evidence.

- What is the plus value of a collaborative approach to general practice from the patient’s point of view?
5. Redefining clinical roles and competencies
Collaborative practice in primary care highlights the specific clinical contribution made by each of the many professions involved, beginning with the general practitioner.

- What is the specific clinical process followed by the general practitioner?

- What are the specific competencies that must be mastered by physicians and nurses working in primary care in order to work in a collaborative context?

- What should be included in the interdisciplinary training offered to members of the various professions working in primary care?

- How can the rules of accountability and legal responsibilities be reconciled with the professional independence or sharing of clinical tasks implied by collaborative practice?
APPENDIX 1

PROGRAM OVERVIEW

Theme I: Redefining the Division of Clinical Tasks and Terms of Collaboration

EXAMPLES OF COLLABORATION:

Redefining Together the Roles of Each: Experience in the Field

Daniel Way, MD, Director of Postgraduate Education
Department of Family Medicine, University of Ottawa

Linda Jones, RN(EC), BSN, CFNP
School of Nursing, University of Ottawa

Collaboration Between Family Physicians and Nurses in England

Peter Weaving, MD, Director,
Eden Valley Primary Care Trust, Carlisle, United Kingdom

Gillian Ridley, BSN, Community Team Leader, Clinical Lead
School of Nursing, United Kingdom

WORKSHOP: The Nurse in Primary Care: Imagining a New Role
The Nurse Practitioner: An Overview of the Canadian Experience

Alba DiCenso, RN, PhD, Professor
School of Nursing, McMaster University

The Nurse in Primary Care: Proposals for a New Role Within the “Family Medicine Group”

Édith Côté, RN, MSc (Epidemiology), MSc (Education), Professor
Academic Vice-Dean, Faculty of Nursing, Laval University

ROUND TABLE AND PLENARY

Chaired by: Rénald Bergeron, MD, Associate Professor
Director, Department of Family Medicine, Laval University

Theme II: New Ways of Organizing Clinical Work: Group Practice, Systematic Follow-Up and Practice in Networks

New Ways to Organize... But to What End? The Public’s Perspective

Yannick Villedieu, Host, Science and Medicine Journalist, Radio Division, Radio-Canada

WORKSHOP: How to Successfully Implement Primary Care Teams

EXPERIMENTS IN QUEBEC AND ACROSS CANADA:
Systematic Follow-Up in Primary Care: What Might It Look Like?

June Bergman, MD, CCFP, FCFP, Medical Director
Primary Care Initiative, Calgary Health Region (CHR).
Creating Networks of Territorial Accessibility: The Bois-Francs Experience
Claudine Archambault, MD
Suzor-Côté CLSC
Co-Director, The Bois-Francs FMG

How to Optimize the Concept of Group Practice
Serge Dulude, MD, Director—Regional Department of General Medicine
Regional Authority for Health and Social Services, Montréal-Centre

ROUND TABLE AND PLENARY
Chaired by: Odette Doyon, RN, MEd, PhD candidate, Professor and Departmental Director,
Department of Health Sciences, University of Quebec at Trois-Rivières

CLOSING DISCUSSION
Jean-Louis Denis, PhD, Professor
Chair, Change and Governance in Health Care Organizations
Department of Health Care Administration, University of Montreal

Theme III: Successful Implementation of Complex Changes

Succeeding at Change: Conditions for Success
Claude Béland, Outgoing President and CEO
University of Montreal Hospital Centre Implementation Corporation (SICHUM)
Former President, Mouvement des Caisses Desjardins

NATIONAL AND INTERNATIONAL EXPERIENCE:
The Ontario Experience
Ruth Wilson, MD, President
Ontario Family Health Network

The Australian Experience
Grant Russell, MBBS, FRACGP, DRANZCOG, MFM
National Director of Clinical Policy and Research
Royal Australian College of General Practitioners

The Quebec Experience
Jean-Guy Émond, MD, President
FMG Implementation Support Group
Quebec Department of Health and Social Services

ROUND TABLE AND PLENARY
Chaired by: Terry Kaufman, Executive Director
CLSC NDG/Montreal West

The Path Taken and a Vision for the Future: Competencies to Be Developed
Vania Jimenez-Sigouin, MD, Associate Professor, Investigator
McGill University, Director of Family Medicine, CLSC Côte-des-Neiges.
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