

LEADERSHIP IN FAMILY MEDICINE:

FROM THE PERSONAL TO
THE POLICY LEVEL





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INTRODUCTION

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FOREWORD

Family medicine – or General Practice, as it is known in some countries – is an emerging speciality. In some places, for example the United Kingdom and the Netherlands, it has been at the heart of the health service for many years: but many others are only just beginning to recognise its potential to strengthen primary health care and achieve affordable and effective front line medical care.

This period of transition is often challenging for the family doctors themselves, as they need to learn to argue for what they do; to create and innovate in practice, and to make important decisions about how to work with other professionals, their communities, and the political context. In clinical training, skills of management and leadership are often less emphasised in the curriculum than those of direct patient care, and many come into family medicine without a clear understanding of the evidence that can help them be effective leaders – whether at the practice level, or in a more academic or managerial role. So, this FreeBook draws on some of the many CRC Press texts to highlight key areas, and hopefully whet your appetite for reading more! It starts with one of the many important papers about family medicine, highlighting the key barriers and ways to overcome them as the speciality moves forward: then goes back to basics, looking at how a medical school curriculum can use family medicine to enhance professional learning and develop early leadership competencies in medical students. We then look at leadership in team work, both from the practical group work perspective, and in effective inter-professional practice, touch on the importance of leadership for research as well as service delivery, and end with a text on working at the healthcare system level. Enjoy!

Professor Amanda Howe OBE FRCGP MA MD MEd
President, World Organisation of Family Doctors (WONCA)

CHAPTER SUMMARIES AND INSIGHTS

CHAPTER 1: THE DEVELOPMENT OF FAMILY MEDICINE AROUND THE WORLD, FROM *FAMILY MEDICINE: THE CLASSIC PAPERS* (KIDD, HEATH AND HOWE)

As the preface says, “*In this book we have endeavoured to collect in one place the classic papers from family medicine from around the world. This book aims to serve as a showcase of some of the most important ideas and research carried out in, or about, family medicine, demonstrate the broad scope of primary healthcare delivered by family*



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doctors around the world, and serve as an inspiration to current family doctors as well as to doctors in training and medical students.” All the papers are relevant to different aspects of family medicine, and each has a commentary by a leading WONCA family doctor on why they chose the paper, and why they think it matters to their practice.

On the theme of leadership, much of this book addresses ‘Leadership for what?’, setting out the arguments for why family medicine matters to a strong health system. The book includes papers from ‘guiding stars’ such as Barbara Starfield and Ian McWhinney, outlining the holistic and patient – centred method which underpins personalised diagnosis and effective care in the primary care setting. It also contains a number of papers which issue strong challenges to the family medicine community – to ensure that we have an academic profile and evidence for our discipline, address the unique challenges of rural and remote family practice, and construct our practices to address the excess and preventable morbidity caused by poverty and disadvantage. For this e-book, the chapter on Cindy Haq’s seminal paper from 1995 best gives us both the barriers to creating strong family medicine, and some solutions – as follows:

List 1 Barriers

1. Failure to appreciate that family medicine is a specialty
2. Failure to understand the need to integrate clinical and community health skills and services
3. Failure to understand the need to integrate preventive with curative care
4. Preference for selective over comprehensive care
5. Historical trends toward medical subspecialization
6. Increased dependence on tertiary care technologies
7. Disproportionate funding of tertiary care
8. Preference for urban versus rural health development
9. Low intra-professional status of family physicians
10. Limited training opportunities in primary care
11. Lack of family practice leadership and role models
12. Medical education biased toward subspecialty training in hospital settings
13. Lack of commitment to comprehensive, accessible, primary health care.



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List 2 Strategies for Successful Global Development of Family Practice

1. Obtain political and financial support for universal access to primary care
2. Integrate public health and medical care
3. Upgrade the status of general practitioners
4. Develop family physician faculty and clinician role models
5. Develop undergraduate (medical school) curriculum
6. Develop postgraduate (residency) curriculum
7. Engage subspecialists in training and work with family physicians
8. Develop organizations of family physicians
9. Establish specialty board certification with national medical society status
10. Encourage governments to take a more active role
11. Involve leadership of international health organizations
12. Work with leadership of international family medicine organizations.”

All of us, both within our local contexts as practitioners, team leaders, and teachers, can act to assist many of these as we grow our discipline – and aim to sustain it for the longer term. How we can do this is set out in subsequent e-chapters, and addressed by other texts in the e-book.

CHAPTER 2: PREPARING TO PRACTICE, FROM A *TEXTBOOK OF GENERAL PRACTICE* (STEPHENSON)

One of the most important levers for change in a health system is who gets into medical school, and what they learn while they are there. Countries which are new to family medicine often find challenges in their early years, as they attempt to become a recognised part of the university and the curriculum of the students. This UK textbook provides a robust and detailed vision of what can usefully be taught in and through family practice teams. It addresses both clinical skills and knowledge built around common conditions managed in the community setting, and also the broader scope of exposing students to patients in their own homes. Emphasis on communication, the role of the team, and indeed on the development of the students themselves mirrors the values of family medicine as a discipline, and is an important part of orienting any future doctor to the needs of patients and the work of family doctors.



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The textbook also puts a strong and useful focus on the professional competencies needed for clinical practice. Chapter 15 provides an introductory framework for helping any learner think about their own thought processes, their need to take responsibility for their own learning, and the need for conscious insight and critical thinking. The conclusion says:

“... the most important messages of this chapter are as follows:

- Being aware of how you think and make decisions helps improve how you consult with patients.
- Reflective learning is easy and helpful.
- Fostering and maintaining relationships with colleagues is crucial to clinical team working.
- Organizing your time and resources helps in your working day.
- Being honestly self-aware is healthy and productive.
- Feedback from peers, colleagues and patients is a valuable resource.
- There are a multitude of ways to keep learning.
- Productive learning is satisfying and fun.”

In terms of developing leadership, this chapter, and the textbook as a whole, assists readers both to get a really good briefing on what family medicine can usefully offer to the modern medical school curriculum. It also reminds us as family doctors and adult learners of some of the key competencies expected of us by the public and our trainees and students. It is a good ‘revision guide’ from a CPD perspective, and will also help those tasked with setting up placements in family practice for learners from undergraduate and postgraduate backgrounds.

CHAPTER 3: WORKING TOGETHER: WHY IT’S IMPORTANT AND WHY IT’S DIFFICULT, FROM A HANDBOOK FOR INTER-PROFESSIONAL PRACTICE IN THE HUMAN SERVICES: LEARNING TO WORK TOGETHER (LITTLECHILD, SMITH)

The Handbook raises our sights to another level of leadership – working with other professionals. It is a scholarly work, with quite intense analytical text about “*team working, boundary issues, and power and status issues between professionals, all set within policy/legal and theoretical and practice-oriented perspectives*”. It uses examples in service such as child safeguarding and the care of vulnerable adults to show how effective inter-sectoral collaboration can be achieved. It also, as with other e-books



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in this collection, summarises essential features that underpin likely successful patient outcomes, and guide us as leaders as to what is fundamentally required. For example, in chapter 8, case studies are repeatedly drawn to useful and succinct conclusions on the preconditions for success:

“Core values for systems development

Attwood et al. (2003) identified ten core values which were essential to the success of whole-system development. They were: Optimism, empathy and humility, tenacity and courage, learning, ongoing relationships, a whole-system perspective married to ‘local knowledge for local solutions’, celebrating small steps and taking the long view.

Sellman (2010, p. 159) takes this a step further and discusses a ‘willingness condition’ which an individual must have in order that the team can most effectively meet an individual’s needs. It is described as ‘the willingness to do whatever is required to contribute to effective team working. This includes a willingness to put the needs of the team on an equal, if not higher, footing than their personal needs’.

Adapting this concept further, the inter-professional willingness condition is the willingness to do whatever is required to enable effective inter-professional working that will meet the needs of Phillip and his family, so placing their needs equal if not higher than the needs of individuals within the interprofessional team.”

There are also introductions to the multiple disciplines of primary health care, which may be of particular interest to those setting up reformed teams and wanting to understand better the roles of e.g. physiotherapists or pharmacists in this setting.

Chapter 1 provides the overview for the book, and is released here to stimulate and give the reader a real insight both into the rationale and some of the pitfalls of inter-professional working. It takes a strong psychological position, drawing our attention to issues such as professional competition for status and opportunity; this, in my experience, can be a particular vulnerability for family doctors in the primary care context, where arguments are repeatedly made for training one type of health professional at the expense of (rather than in co-operation with!) another. Building the systematic and relational basis for mutual development will benefit both our



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patients and ourselves in the longer term. The chapter invites us to reflect explicitly on issues such as “*Do you hold stereotyped views of any other professional groupings within social care or health? Do you think these stereotypes have any basis in fact? Is it better to share them with colleagues or to suppress such beliefs in the interests of good working relationships?*” Such a discussion may be needed between medical disciplines across secondary and primary care sectors, as well as between different health care professional groups.

To summarise, there are particular challenges for family medicine leaders when trying to build collaborations with colleagues both in their own clinics and in the broader system – we have to sustain our teams for the long term, often overcoming challenges of resourcing, and always need to improve our standards – rather than accepting ‘second best’. Getting the team to be committed to each other and to a high quality of service for patients is a real leadership challenge, where actions speak louder than words. This book gives many good approaches to how to do this in practice – and what our focus needs to be to achieve it.

CHAPTER 4: WHAT IS A GROUP? AND WHAT DOES IT DO?, FROM *GROUPS – A GUIDE TO SMALL GROUP WORK IN HEALTHCARE MANAGEMENT EDUCATION AND RESEARCH* (ELWYN, GREENHALGH, MACFARLANE)

Having learned about the best ways to work across professional boundaries, this book is the golden guide to how to conduct meetings, discussions, and teaching sessions in a way that makes them work! Many brilliant ideas and plans have fallen over because the leaders who advocated for them did not know how to get other people engaged and working together towards common goals. Doctors are rarely taught about group dynamics – the chapter released here asks the simple question “What is a group? And what does it do?”, then setting out some very fundamental principles which can make or break a successful session. Whether your role as a leader involves running staff meetings, curriculum committees, community engagement sessions, or professional and political networks, this book is an invaluable guide. It teaches the principles of groupwork, a skill you will use most days in a working lifetime.

CHAPTER 5: STORIES AND ORGANISATIONS, FROM *WHAT SEEMS TO BE THE TROUBLE? STORIES IN ILLNESS AND HEALTHCARE* (GREENHALGH, GOOZNER)

This is a fascinating book which highlights the importance of narrative in medicine, especially in family practice where the way the patient is encouraged to tell their



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story is often a major contributor to both diagnosis and successful outcomes. But in the context of leadership, Chapter 4, on 'Stories and Organisations', is the most relevant for those of us trying to achieve change and improve quality. Leading on from the points made by earlier chapters about the importance of relationships and interpersonal dynamics, this chapter draws on material from management theory that will be unfamiliar to most family doctors, encouraging us to use stories told by different stakeholders to understand – and potentially shift – the culture of the organisation. Professionals are often taught to use 'significant event analysis' or 'root cause analysis' to look at problematic areas of practice such as major complaints or patient safety issues: but *how* this is done, both intellectually and emotionally, can make the difference between motivating professionals for improvement and undermining their confidence. It is published here because it invites leaders to be both innovative and smart in how they manage their team and organisational process – acute listening, then reframing the discussion if needed to improve focus and outcome. If you can do this with colleagues from different backgrounds to achieve a common goal, in a way that supports them and improves outcomes, you are becoming a real leader!

CHAPTER 6: THE CONTRIBUTION OF PRIMARY CARE RESEARCH TO EDUCATION, TRAINING AND DEVELOPMENT, FROM *INTERNATIONAL PERSPECTIVES ON PRIMARY CARE RESEARCH* (GOODYEAR-SMITH, MASH)

Although the title may not suggest it, much of this book is about the need for leadership – this time in securing resources for research, being active in delivering it, and in ensuring that evidence relevant to primary care patients is used for policy and practice. The book sets out the case for research, gives many examples of research networks and funding models from around the world, and has a number of very interesting chapters on the links between PC research and high quality services, patient safety, and the overall improvement of family medicine when linked with academic activities. For many family doctors, our main use of research will be when it alters practice – new interventions, new treatments – or when we host studies and collect data for research projects. This in itself is an important contribution, as data on our patients will usually require us to invest some time and effort in securing their consent and getting the studies set up – but without this the research will not happen, or will happen only in hospital settings that do not reflect the breadth and length of our patients' needs. It is not a technical book full of statistics and methodological information – instead, it paints an enriching picture of the current



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state of primary care research, and issues of best practice such as patient and community involvement in the choices and outcomes of research.

The e-chapter chosen links these issues with the particularly important one for leaders of how to ensure that research is relevant to the needs of the population, and is used by practitioners and teachers in a way that develops an effective and socially conscious workforce. It uses fascinating examples of how research approaches can be used for such fundamental issues as human resource gaps, causes of maternal and child mortality, and potentially to inform policies that might reduce the worldwide 'braindrain' from weaker to stronger economies. The brief case studies include insights into how teams learned for themselves in the process of participating in some of the research studies – again, a leadership skill to ensure that there are benefits for the service practitioners who assist with research. Many other chapters also have relevant lessons for practitioners and academics – this one is a taster!

CHAPTER 7: CREATING A SUPPORTIVE ENVIRONMENT FOR OPTIMAL FAMILY PRACTICE, FROM *THE CONTRIBUTION OF FAMILY MEDICINE TO IMPROVING HEALTH SYSTEMS: A GUIDEBOOK FROM THE WORLD OF FAMILY DOCTORS* (KIDD)

And finally – the big leadership challenge of changing the system as a whole. Aply set out in this WONCA text, the book overall “... *systematically analyses the contribution of family medicine to high quality primary health care in addressing the challenges faced by current health systems, and provides options for moving forward. It serves as a pragmatic guide to potential strategies for putting in place family care teams which effectively contribute to health sector development within a variety of contexts*”. This book was designed for family medicine leaders, although of interest to others as well. It sets out the key features of mature family medicine – first point of medical contact, offering comprehensive care across time, co-ordinating and helping to direct the use of other relevant services (co-ordination) and using preventive as well as acute and chronic care approaches in a way that takes into account the context of the individual, their family and community. It addresses why a good health care system aiming for cost-effective universal health coverage will need family medicine, how to build the discipline up, and gives case examples from all regions of the world of how this can be achieved. It brings together many of the themes highlighted in the previous e-chapters, but also rehearses the argument that a family medicine leader in a professional organisation, or medical school, or other strategic role would need to persuade ministries and employers and financiers of the case for family medicine.

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The e-chapter 5 ‘Creating a supportive environment for optimal family practice’ brings us back to some of the issues raised in Haq’s paper – but gives much more detail about what this means in practice. It addresses the key dimensions of family medicine, the components of academic and professional networks and their contribution to the development of the discipline, and echoes the previous chapters in some of its emphasis on successful relationships, teamwork, and evidence based practice. It also highlights the importance of strategic planning and goal setting, whether this be for an agreed improvement in service delivery, or in achieving an effective curriculum or training programme. And it headlines a number of successful case studies which demonstrate the ‘building blocks’ to creating and sustaining family medicine in the system. If this is our ultimate goal as leaders, this chapter (and the book as a whole) can help us remember what is needed, and map our own efforts onto the learning of others.

Note to readers: References from the original chapters have not been included in this text. For a fully-referenced version of each chapter, including footnotes, bibliographies, references and endnotes, please see the published title. Links to purchase each specific title can be found on the first page of each chapter. As you read through this FreeBook you will notice that some excerpts reference previous chapter – please note that these are references to the original text and not the FreeBook.

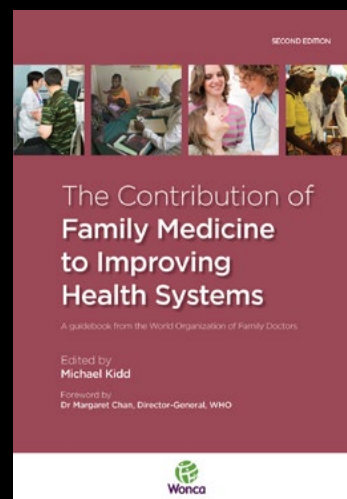
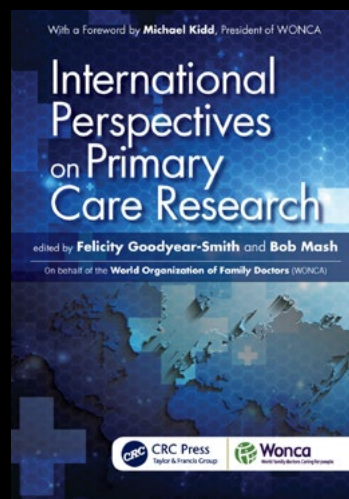
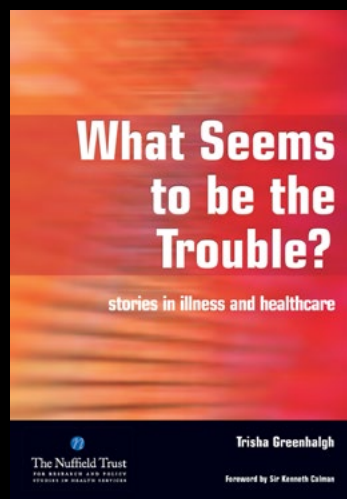
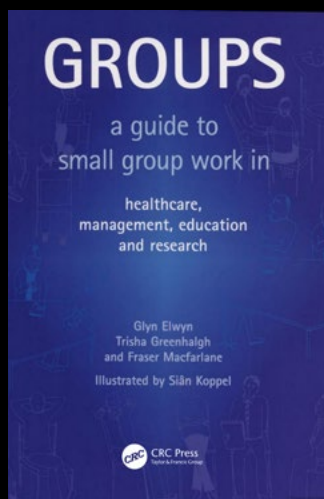
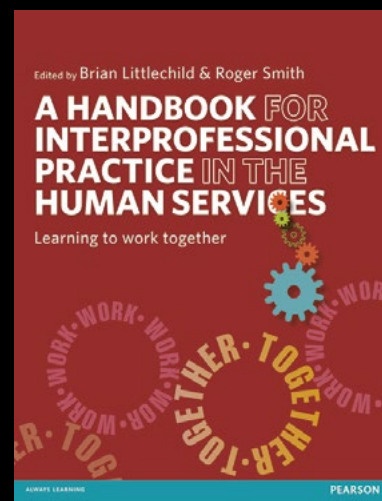
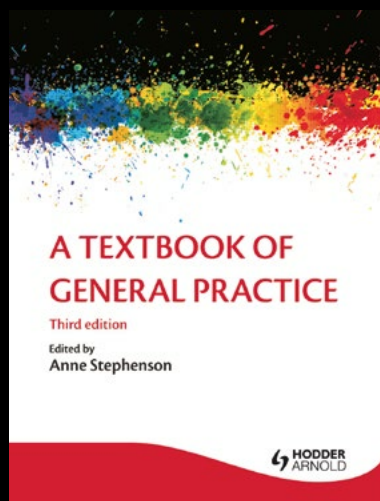
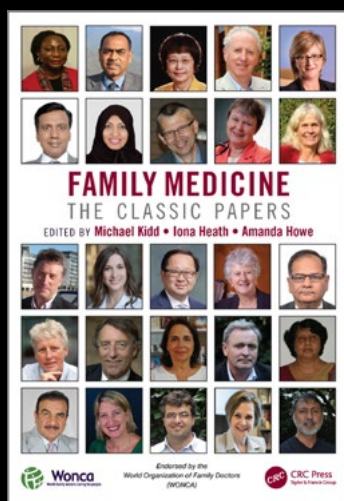


ABOUT WONCA

The World Organization of Family Doctors (WONCA) is a not-for-profit organization and was founded in 1972 by member organizations in 18 countries. WONCA now has 118 Member Organizations in 131 countries and territories with membership of about 500,000 family doctors and more than 90 per cent of the world’s population. This includes eight organizations in collaborative relations with WONCA. There are some 21 members in the Academic membership category, which consists of Academic Departments of Family Medicine. Over 800 individual general practitioners and family physicians have chose to join WONCA in their own right.

WONCA represents and acts as an advocate for its constituent members at an international level where it interacts with world bodies such as the World Health Organization, with whom it has official relations as a non-governmental organization and is engaged in a number of collaborative projects. The WONCA World Secretariat has transferred from Singapore to Bangkok, in November 2012.

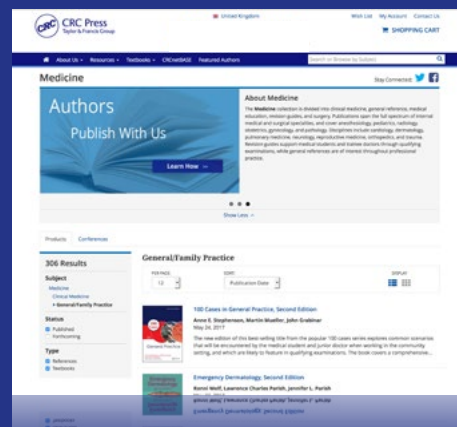
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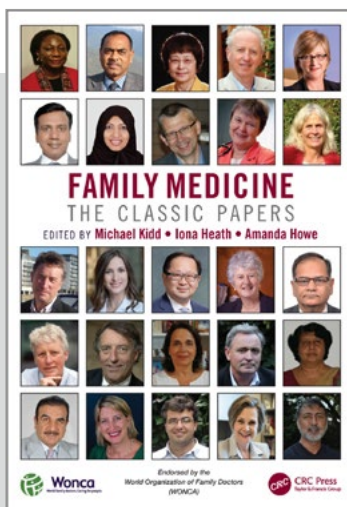
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CHAPTER

1

THE DEVELOPMENT OF FAMILY MEDICINE AROUND THE WORLD



This chapter is excerpted from

Family Medicine: The Classic Papers

By Michael Kidd, Iona Heath, Amanda Howe

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THE DEVELOPMENT OF FAMILY MEDICINE AROUND THE WORLD

Luisa Pettigrew and Cynthia Haq

Excerpted from *Family Medicine: The Classic Papers*

NOMINATED CLASSIC PAPER

Cynthia Haq, William Ventres, Vincent Hunt, Dennis Mull, Robert Thompson, Marc Rivo, Philip Johnson. Where there is no family doctor: the development of family practice around the world. *Academic Medicine*, 1995; 70(5): 370–80.

This paper, for the first time ever, mapped the global status of family medicine. The authors build a powerful argument for the need to strengthen family medicine worldwide and of the role of family doctors as cornerstones in the delivery of comprehensive primary healthcare. They highlight the then emergent epidemiological shift from acute to chronic diseases for which broadly trained family doctors are a necessity. Recognising that while the skills required by family doctors may vary according to population needs, health facilities and resources available, they emphasise that the principles of family medicine are universal. The authors identify 10 barriers to the global development of family medicine and propose 10 strategies to overcome them. The paper includes case examples of the development of family medicine in South Korea, Venezuela and Pakistan.

The paper was a milestone in the global development of family medicine and a seminal publication describing the history and logic for training family doctors. It was published at a time when many countries did not yet consider family medicine a legitimate medical specialty. The content caught the attention of medical educators and provided a rationale for the global expansion of the specialty. It served as the basis for the original 2002 Guidebook on the contribution of family medicine to improving health systems by the World Organization of Family Doctors (WONCA), and for further collaboration with the World Health Organization. It provided evidence for renewed emphasis on human resources and primary healthcare as critical components of successful health systems.

So, 21 years on, has family medicine come of age? Undoubtedly there are new case studies that could be generated to update the original paper. However, there are still many places where access to comprehensive primary healthcare and well-trained family doctors remains a distant reality. The barriers identified in 1995 resonate with the challenges numerous countries still face to train and retain sufficient numbers of family doctors who can provide comprehensive care, and provide that missing link across various levels of health and social care settings. Likewise, most of the strategies proposed for the successful development of family medicine are still applicable in many settings. This makes this paper as relevant now as it was when first published. This paper confirmed that the principles and challenges of family medicine are universal. It

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Excerpted from *Family Medicine: The Classic Papers*

helped inspire the global expansion and increased numbers of family doctors who now contribute to primary healthcare and the well-being of people throughout the world.

ABOUT THE LEAD AUTHOR OF THIS PAPER

Cynthia Haq is Professor of Family Medicine and Community Health at the University of Wisconsin in the United States of America, and a champion for primary healthcare and medical education to promote health equity.

Cynthia received her medical degree at Indiana University. Early in her career she served as medical director for a rural health centre in Kasangati, Uganda where she learned the importance of primary healthcare, community and public health. She has served as a Fulbright Scholar at the Aga Khan University in Karachi, Pakistan, worked at the faculty of Makerere University, Uganda, and at Addis Ababa University in Ethiopia to introduce and strengthen family medicine. She co-authored the first edition of the WONCA Guidebook on the contribution of family medicine to improving health systems. She has served as a consultant for various national and international organisations, has published widely, and has won multiple awards for her achievements.

Cynthia practised full-scope family medicine in rural Wisconsin from 1989 to 2008. She now leads a programme to prepare students for working with urban medically underserved populations and continues global health collaborations. She is also the proud mother of four children.

ABOUT THE NOMINATOR OF THIS PAPER

Dr Luisa Pettigrew currently works as a family doctor in London and a research fellow at the London School of Hygiene and Tropical Medicine. She is passionate about the contribution of primary healthcare and family medicine to global health. Luisa serves as an elected member-at-large of WONCA's global executive committee and as WONCA's liaison person to the World Health Organization.

'Step off the medical training treadmill when you can. Seize opportunities to immerse yourself in other cultures; do so thoughtfully. Learn from different health systems and develop friendships with international colleagues. It can surprise, inspire and enthuse. It may give you a new perspective of your own health system and of how you could contribute to better health globally.'
Dr Luisa Pettigrew, United Kingdom

THE DEVELOPMENT OF FAMILY MEDICINE AROUND THE WORLD

Luisa Pettigrew and Cynthia Haq

Excerpted from *Family Medicine: The Classic Papers*

ATTRIBUTION:

We attribute the original publication of *Where there is no family doctor: the development of family practice around the world* to *Academic Medicine*. With thanks to the authors of this paper, to David P. Sklar, MD, Editor-in-Chief, and to Mary Beth DeVilbiss, Managing Editor.

WHERE THERE IS NO FAMILY DOCTOR: THE DEVELOPMENT OF FAMILY PRACTICE AROUND THE WORLD

ABSTRACT

Family physicians are generalists trained at the postgraduate level to address the majority of primary care needs of patients of all ages in communities they serve. Throughout the world there is a need for family physicians to serve as cornerstones of comprehensive healthcare systems that provide high-quality, cost-effective medical and public health services to the entire population. To meet this need, each country must value and adequately finance essential medical and public health services and must provide family physicians with a thorough education focused on the relevant healthcare problems of the population being served. The authors present an overview of the status of this training throughout the world, outline challenges to the development of such training, and suggest strategies for successful development accompanied by illustrative case studies from South Korea, Venezuela, and Pakistan.

Acad. Med. 70(1995):370-380.

The recent debate on health care reform has brought to the forefront the need for well-trained generalist physicians in the United States. Physicians and policymakers have focused attention on training more family and other primary care medical practitioners to provide high-quality accessible medical care. These concerns are not confined to the United States; recently, there has been a global call for expanded training of primary care physicians.

Primary medical care is the field of medicine that provides first-contact, comprehensive, curative, and preventive health care services. These services are delivered by primary health care teams that include physicians, community health nurses, village health workers, and other health professionals. Primary care

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Excerpted from *Family Medicine: The Classic Papers*

or generalist physicians in the United States include family physicians, general internists, and general pediatricians. Family physicians are the only generalist physicians trained to care for patients of all ages. Because of their ability to provide comprehensive, continuous care to patients of both sexes and all ages, and to cost-effectively integrate preventive and curative care, family physicians are well suited to address comprehensive primary health care needs of people in developed and developing nations.

Family physicians are generalists trained at the postgraduate level to address the majority of primary health care needs of patients of all ages in the communities they serve. Training and terminology for these physicians vary throughout the world. For example, in the United States and Canada, such physicians are called family physicians and their academic specialty is called family medicine; in Great Britain and other Northern European countries, the most common terms are general practitioner and family practice. In this paper, we use the term family practice to describe this medical specialty designed to provide comprehensive care for patients of all ages and both sexes. We use the term family medicine when that is the formal name for the specialty or department in a particular country or school.

While “the principles of family medicine are universal,” the skills required of family physicians to adequately address the primary health care needs of the patients and communities they serve vary, depending on location of the practice, the diseases prevalent in the region, the resources available, and the proximity to other health care services. In some countries family physicians are active in the care of hospitalized patients (Canada, United States, Nepal), while elsewhere they are based almost exclusively in ambulatory care settings (United Kingdom, Latin America). In most countries, family doctors work as integral members of primary health care teams along with other allied-health professionals.

Even though family practice is expanding throughout the world, many countries still do not have family doctors, due to conceptual, political, financial, and professional barriers. We present strategies to address these barriers and promote successful family practice development.

THE INTERNATIONAL NEED

Since 1978, when the World Health Organization (WHO) began its Health for All program, primary health care has figured prominently in the development plans of government agencies, international donor groups, and nongovernmental

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Excerpted from *Family Medicine: The Classic Papers*

voluntary organizations. These organizations have concentrated on promoting both comprehensive and selective primary health care, with an emphasis on public health programs, while focusing limited attention on the appropriate roles of medical care, the physician workforce, and medical education. Today, much of the world's population still lacks access to comprehensive primary care services. This need is most striking in developing nations, but it is also present in many developed countries, where imbalances in the training and distribution of physicians result in shortages of generalist physicians, especially in rural and inner city areas.

In order to address primary healthcare needs in developing countries in a cost-effective fashion, many countries have trained cadres of community health workers to implement UNICEF's GOBI-FF (growth monitoring, oral rehydration, breast feeding, immunizations, fertility control, and female education) strategies. These interventions have been important and have been shown to reduce infant mortality by more than half in many communities. However, improvements in infant survival rates have leveled off in these communities, and there have been fewer positive changes in adult morbidity and mortality.

In addition, developing countries show shifts in the patterns of diseases observed over time. An initial preponderance of infectious diseases is shifting to a preponderance of chronic illnesses coupled with an increase in diseases related to behavior and the environment. In most developing countries, infectious diseases are the leading causes of child deaths, while chronic diseases are the leading causes of adult deaths. Practitioners in developing countries may face concurrently high infant mortality and expanding aging populations with their burden of chronic disease. These changes necessitate services considerably beyond the capabilities of the community health worker and call for a more sophisticated and broadly trained family physician.

While changes within the public health sphere have been under way, changes have occurred within medical education that have produced a worldwide consortium of community oriented medical schools¹⁰ and a call for academic medical centers to assume responsibility for population-based healthcare. The 1993 World Summit on Medical Education, attended by 240 medical educators from 80 countries, called for "doctors to promote health, prevent illness, palliate disability, become health team managers, advocates for communities, and providers of primary care." The World Health Organization has called for a "paradigm shift in medical education, challenging universities to leave their cloistered environment, assume responsibility

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for the health of local populations, and to develop curricula that engage faculty and students in population-based medical education.” These and other proposed models for community-responsive medical education, while focusing on the importance of restructuring the academic environment, have given less emphasis to the establishment of a viable and functioning generalist physician work force.

The quality of training for generalist physicians varies throughout the world. In many countries, general practitioners are simply non-specialists who receive limited to no postgraduate training in the provision of primary care. Typically, in these countries medical students have little contact with ambulatory patients and limited instruction in primary care and prevention. As a result, these students fail to gain the skills necessary to function as competent generalist physicians.

Concerns about the relevance, quality, cost-effectiveness, and equity of medical care are growing in importance internationally and focusing renewed attention on the important role of the well-trained generalist physician. Studies demonstrate that residency-trained family physicians provide high-quality, cost-effective care for a broad range of problems at the entry-point of a health care system. Furthermore, the quality of care provided by family physicians has been found comparable to that of other specialists in a variety of areas, including uncomplicated obstetrics and perinatal outcomes, congestive heart failure, and critical care.

The continuity and comprehensiveness of care provided by well-trained family physicians are closely linked with improved quality. Franks and colleagues reviewed eight studies that correlate these characteristics with improved outcomes for patients of all ages, including higher birthweight, reduced morbidity in children, and reduced hospitalization of the elderly.

Today, many individuals and organizations throughout the world are working to increase the relevance of medical practice and medical education and to enhance the role of the general practitioner in health care delivery. In October 1993, the Health Resources and Services Administration (HRSA) and Brown University School of Medicine cosponsored the International Conference on the Education of Family Physicians at the National Institutes of Health. A manual is being developed from this conference to assist those family medicine educators asked to serve as international consultants for developing family practice training programs. In June 1994, the first Global Conference on International Collaboration in Medical Education Reform met in Rockford, Illinois. Cosponsored by the WHO and the University of Illinois College of Medicine at Rockford, the conference helped launch a global network of community oriented medical schools

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to collaborate on new models of population-based medical education. In November 1994, the WHO and the World Organization of Family Doctors (WONCA) cosponsored in London, Ontario, a global strategic action forum, "Making Medical Practice and Medical Education More Responsive to Public Need: The Role of Family Doctors." Subsequently, the WHO and the WONCA collaborated on an action plan for achieving the "Health for All" goals, aimed at enhancing the relevance of medical practice and medical education and emphasizing the role of general practitioners in health care delivery. In January 1995, the WHO's executive board formed a resolution developed from the recommendations of the WHO-WONCA report 24 and recommended that it be adopted at the 49th World Health Assembly in May 1995.

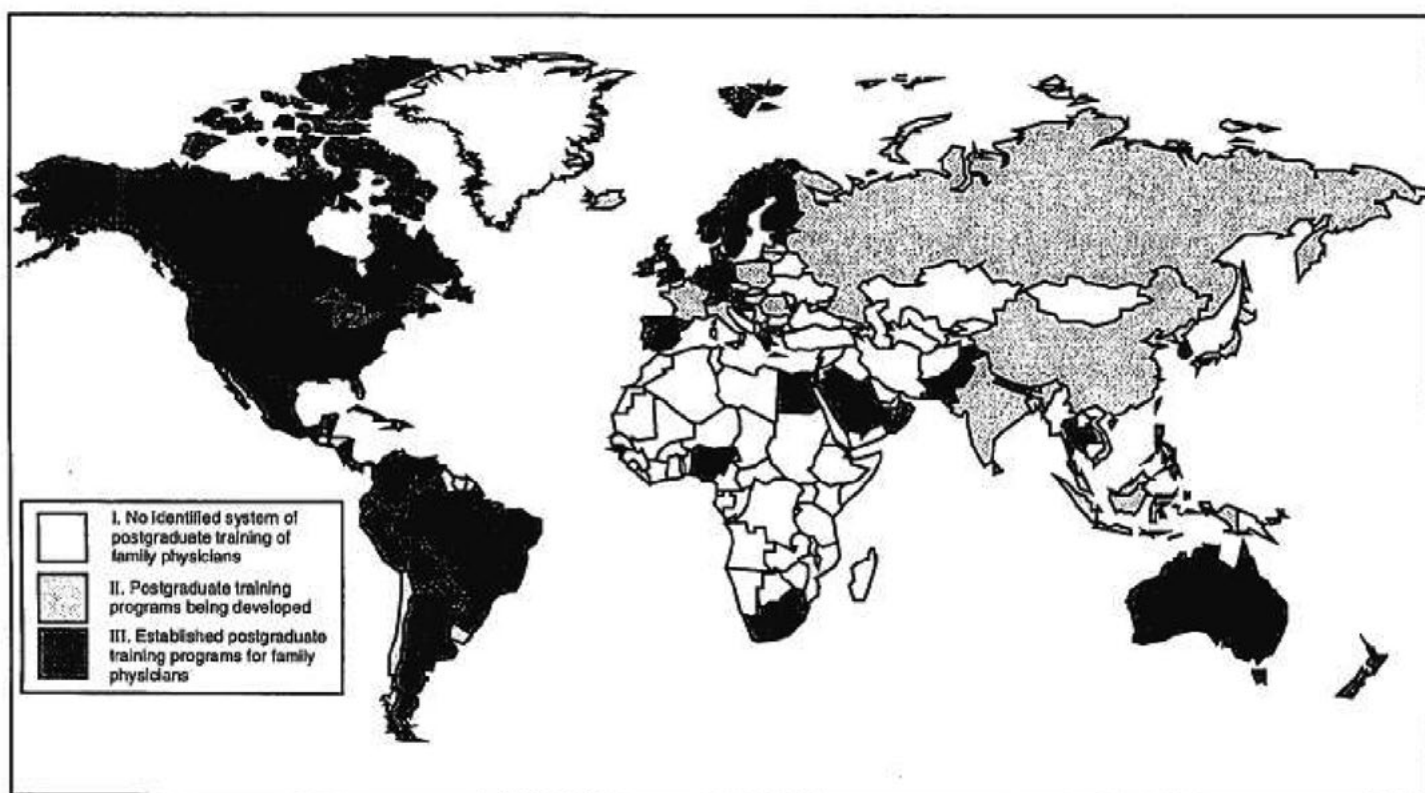


Figure 1

THE CURRENT GLOBAL STATUS OF FAMILY PRACTICE

The map (Figure 1) summarizes the information we have gathered regarding the training of family physicians around the world at this time. For simplicity and for the sake of comparison, we delineate three levels of the status of family practice:

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- I. No identified system of postgraduate training of family physicians
- II. Postgraduate training programs being developed for family physicians
- III. Established postgraduate training programs for family physicians

The data presented were gathered from a number of sources, including reports in the *WONCA News* over the last six years, 25 personal files, reviews, and preliminary results of a comprehensive survey of postgraduate generalist training in member countries of the WONCA. The latter survey was an extensive cross-sectional study conducted by the Department of Family Medicine at Brown University and HRSA. A 30-page, self-administered branching questionnaire was mailed to 130 persons in 66 countries identified as key individuals from the WONCA directory. Sixty-seven individuals representing 52 countries from all continents responded.

The map is intended to provide an approximate indication of the progress of family practice throughout the world. Because of the difficulty in defining terms and obtaining accurate data for countries in transition, some level I countries may have training programs that we were not able to identify. The situation is also changing rapidly as many countries begin to plan or implement training programs for family physicians. Furthermore, countries indicated at the same level are not necessarily identical in their development of family practice. Some level III countries may have only one certified training program for family physicians, while others may have hundreds. There are considerable differences among countries in requirements for certification, requirements for accreditation, continuing medical education, and the percentages of postgraduate trained generalists providing care. Data from the WONCA survey and other sources suggest that at least 56 countries have postgraduate training programs in family practice. Of note, half the programs were established after 1970, an indication of the rapid growth and relevance of the specialty and of the need to enhance training for general practitioners.

NORTH AMERICA, THE CARIBBEAN, CENTRAL AND SOUTH AMERICA

Many stages of family practice development are evident in the Americas. Family practice is well established in Canada, where all 16 medical schools have departments of family medicine. Family physician faculty are actively involved as teachers in the undergraduate medical curriculum, and about half of medical school graduates pursue careers in family practice. In the United States, since its designation as a specialty in 1969, family medicine has grown to include over 400 residencies. Approximately 14% of 1994 medical school graduates entered these

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programs, and 90% of medical schools have departments or divisions of family medicine. Family physicians in the United States represent 12.7% of all non-federal MDs engaged in patient care. Cuba has developed a comprehensive program of family physician training and placement designed to provide health coverage for all of its citizens. The situation in other Latin American countries is more fluid. Whereas Argentina has many programs, most Latin American countries have limited numbers of residencies with minimal medical school involvement. In the 1970s and early 1980s, family medicine expanded rapidly in Mexico, but recently the number of training centers has decreased considerably. Nevertheless, a cadre of dedicated and committed family physicians is being trained throughout Latin America with encouragement and leadership from several organizations.

EUROPE

Postgraduate training programs for family physicians (referred to as general practitioners in Europe) are well established in the United Kingdom, Ireland, Denmark, The Netherlands, Scandinavia, Portugal, and Spain. Training is less developed in the Southern European countries. Many Eastern European countries are now developing pilot programs. The evolution of family practice in Europe has been affected by the increasing unity of European nations and the breakdown of communist Eastern and Central Europe. For instance, 12 countries of the European Economic Community (EEC) have agreed to the minimum requirement that all generalists receive two full years of postgraduate training, including six months in an approved practice. The European Academy of Teachers of General Practice has been established, as has a European Center for Research and Development in Primary Health Care, with the intention of disseminating information on research and development initiatives in general practice/family medicine within Europe.

AFRICA, MIDDLE EAST, ASIA, AND AUSTRALIA

Family practice training is established in South Africa, Nigeria, and at the Suez Canal University in Egypt. Other African countries have no training or training programs in early stages. In the Middle East, vocational training for generalists is well established in Israel, where all four medical schools have departments of family medicine. The American University of Beirut initiated the first family medicine training program in the Arab world in 1979, followed within months by Bahrain in the Arabian Gulf. Postgraduate training programs are functioning in Saudi Arabia, Kuwait, Oman, and, most recently, in Jordan. An Arab Board of Family Practice sets standards for training programs throughout the Arab world. Also, 14 Asian Pacific countries have agreed

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upon a common core curriculum in family practice that is flexible and adaptable to local circumstances. Among these countries, family practice has been established in Taiwan, the Philippines, Hong Kong, Malaysia, and Singapore, and throughout South Korea. Family practice training has begun in Pakistan and Sri Lanka, and pilot programs are in progress in China, Russia, and India. Australia and New Zealand have well developed postgraduate training programs.

CHALLENGES TO THE DEVELOPMENT OF FAMILY PRACTICE

There are many challenges to producing adequate numbers of appropriately trained family physicians internationally. While these challenges present barriers to the establishment of family practice in developed countries, they form serious impediments to the introduction of well-trained family physicians within primary health care systems of developing countries. These challenges are summarized in [List 1](#).

List 1

Barriers to the Global Development of Family Practice

1. Failure to appreciate that family medicine is a specialty
2. Failure to understand the need to integrate clinical and community health skills and services
3. Failure to understand the need to integrate preventive with curative care
4. Preference for selective over comprehensive care
5. Historical trends toward medical subspecialization
6. Increased dependence on tertiary care technology
7. Disproportionate funding of tertiary care
8. Preference for urban versus rural health development
9. Low intra-professional status of family physicians
10. Limited training opportunities in primary care
11. Lack of family practice leadership and role models
12. Medical education biased toward subspecialty training in hospital settings
13. Lack of commitment to comprehensive, accessible, primary health care

Even in countries where family practice has been established for many years, there is a prevailing view that it is not possible to produce broadly trained generalists who can practice high-quality, cost-effective primary health care. Advances in medical knowledge and technological developments have created the perception that it is too difficult to keep abreast of the broad scope of family practice. This misconception results from the failure to appreciate that family practice is a specialty whose breadth is appropriate for addressing the majority of health needs in the primary care setting.

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Effectively integrating hospital, clinical, and community skills presents additional challenges to family practice.

Since World War II, the model of subspecialized, technologically-dependent medical care, increasingly dominant in the United States, has been exported to developing countries. This emphasis on subspecialty care spurred an increase in health-care financing for tertiary care. In most countries, hospitals now consume the bulk of public spending on health care, and in developing countries hospitals may consume up to 80% of government health budgets. In only a few countries that provide universal access to primary medical care have sufficient funds been allocated for the development of strong primary care programs with adequate personnel and funding. In large part due to the high proportion of spending for subspecialized, tertiary care, the funds available in most countries for the support of primary care training or primary care clinical infrastructure development are limited.

Not surprisingly, primary care physicians throughout the world have endured a lower professional status than their subspecialist counterparts. They usually receive less pay than subspecialty physicians and their working conditions are frequently difficult, with numerous patients to be seen, few diagnostic resources available, and professional isolation from colleagues. Family practice has commonly had difficulty obtaining acceptance within the medical hierarchy as a legitimate specialty, and even in countries where family medicine is recognized, family physicians have had to work hard to establish their domain of medical care and obtain appropriate hospital privileges.

Given these factors and the limited exposure to primary care in medical school, in many countries few students choose to enter generalist careers except by default. Often there are no opportunities to pursue postgraduate training in family practice, as many countries have no such programs.

The political forces that determine medical education and public health policy in many countries frequently do not advocate for the establishment of family practice. There may be conflict between policy-making bodies such as governmental organizations, academic medical centers, and medical associations regarding the balance of medical providers needed and their training requirements. There are usually few advocates for family practice specialists in decision-making positions, especially in countries where a strong system of primary care is not already developed. In such countries, this lack of clinical and academic role models is a serious handicap for development of the field. Additionally, many countries have

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historically separated the provision of clinical and public health services. Clinicians in these systems often have limited experience integrating the provision of preventive care with clinical services, which is a major goal in family medicine.

PROPOSED STRATEGIES

The effective promotion of family practice internationally will require a series of independent yet coordinated efforts from local communities to international organizations. Here we describe strategies relevant to the items in **List 2**, followed by case studies from three different countries that illustrate their applications.

List 2

Strategies for Successful Global Development of Family Practices

1. Obtain political and financial support for universal access to primary care
2. Integrate public health and medical care
3. Upgrade the status of general practitioners
4. Develop family physician faculty and clinician role models
5. Develop undergraduate (medical school) curriculum
6. Develop postgraduate (residency) curriculum
7. Engage subspecialists in training and work with family physicians
8. Preference for urban versus rural health development
9. Low intra-professional status of family physicians
10. Limited training opportunities in primary care
11. Lack of family practice leadership and role models
12. Medical education biased toward subspecialty training in hospital settings
13. Lack of commitment to comprehensive, accessible, primary health care

Obtain political and financial support. National political and financial support for universal access to primary care is critical for securing adequate resources and for developing a system that values primary care. Without this support, educational reform will have limited impact.

Integrate public health and medical care. Community health education lies at the heart of any effective system of primary health care. This includes education of community members about disease prevention, hygiene, common health problems, and when and how to access the health care system. While many primary care initiatives have used community health workers to address these needs, in order to be most effective these workers must be adequately backed up by primary care

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physicians who are trained to care for more complex problems over the broad range of primary health care issues. Education of community members regarding the need for a system of locally accessible, comprehensive primary care that includes family physicians can aid community health development, provide pressure for legislative change, and support the recruitment and retention of such physicians.

Upgrade general practitioners. By upgrading their abilities through competency-based continuing education and professional certification, currently practicing generalists who have not received postgraduate training can improve their capabilities to provide quality primary care at the same time as they enhance their status and contribute to the growing support for and presence of family practice. In addition, national and international journals targeted at generalist physicians are important for sharing professional information, keeping practitioners informed of new developments, and communicating expectations for high standards.

Develop family physician faculty. Strong leaders are needed who can demonstrate excellence in clinical skills as well as effectively teach the principles of family practice. The involvement of primary care physicians familiar with local disease patterns, cultural patterns, and community needs is crucial to assure that training programs are relevant to local needs. In countries without established training for family physicians, leaders can be exemplary local general practitioners, subspecialists who support generalist training, local physicians who have completed postgraduate training out of their native countries, or expatriate family physicians. In countries that have few family physicians, providing these physicians with adequate opportunities to balance patient care with teaching is essential to expanding the field. Fellowship opportunities are available for visiting faculty at selected institutions in the United States, but costs limit out-of-country training opportunities.

Develop undergraduate and postgraduate curricula. Undergraduate programs should provide all medical students with knowledge of community health problems and experience in ambulatory care. These fundamental components of family practice are most effective when taught longitudinally, beginning in the first year of medical school. Early exposure to a generalist curriculum increases the chances of students' choosing generalist careers. Family practice concepts should occupy a position of highest importance in the curriculum, using family physicians or other leaders in primary care as prominent faculty members and role model clinicians. Schools dedicated to producing adequate numbers of family physicians may devote 25% of curriculum time to this effort.

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Residency education typically lasts two to three years, depending on local needs. It should be as rigorous as subspecialty training and carefully evaluated to be sure that it prepares graduates to provide comprehensive primary care with competence in managing problems prevalent in their communities. An examination-based program of certification, followed by requirements for continuing medical education and recertification, assures that practitioners meet quality standards and remain abreast of new developments.

Ultimately, the ability to attract students to careers in family practice depends on a curriculum that emphasizes primary care during medical school, exposure to family physician role models during clinical training, quality postgraduate training opportunities, and career opportunities with attractive salaries following training. Unless there is a differential in pay between the general practitioner with no post graduate training and the residency-trained specialist in family practice, there will be little incentive for medical school graduates to invest additional years in residency training. In developed countries, the differential allocation of rewards based on length of training is accomplished by insurance companies and hospital medical staff regulations. In developing countries, governmental policy can be just as influential. For example, in Mexico, the social security system, the principal health care delivery system for salaried employees, preferentially hired residency-trained family physicians and caused a shift in career aspirations of medical students.

Engage subspecialists. Subspecialists can play a critical role in providing family physicians with a disciplined approach to clinical decision making, recognition of patients with problems that need referral, and stabilization of critically ill patients for transfer. Subspecialists' skills can be most effectively utilized when they work in a coordinated fashion with family physicians and other primary care providers who care for common problems and refer to them patients with more complex diseases. In this manner subspecialists maintain expertise consistent with their training, experience, and orientation.

Create national specialty certification and organizations. Specialty boards set standards for training, define the scope of specialty practice, and define the requirements for examination of new and recertifying members. Specialty certification not only assures a minimum standard of quality, but allows for recognition of standards of practice by patients and other medical practitioners. Without standardized training or certification requirements, there will be wide variations in the practice patterns of self-designated family physicians and the

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qualities of the care they provide, and the specialty will have limited credibility. Officially recognized organizations of family physicians can play a major role in establishment and enforcement of standards of certification.

Involve government. Governments play a large role in the financing of medical education. In many countries they also determine the number of medical graduates and the number of specialty training positions available and their geographic locations. In order to assure that adequate numbers of family physicians are trained, governments must take active roles to redirect funds and address imbalances that have produced surplus subspecialists and shortages of appropriately trained family physicians. In countries that have national health systems committed to providing universal primary health care to all inhabitants, about half of all physicians are generalists who work primarily in ambulatory care settings. In countries whose resources are very limited, primary health care teams with adequate numbers of well trained non-physician providers (village health workers, traditional birth attendants, community health nurses, physician's assistants or nurse practitioners) supported by family physicians provide the most cost-effective primary health care for all.

Involve international health organizations. The World Health Organization (WHO), has served as an important leader in international public health developments, defining important standards of health for all and outlining methods by which all countries can work toward these goals. These standards have been used by organizations such as the World Bank, the International Monetary Fund, and the U.S. Agency for International Development to determine funding priorities for international development efforts. The WHO has articulated the need for generalist physicians throughout the world. This call for action will need broad support in order to be realized.

Work with family medicine organizations. Several medical societies exist that promote both the exchange of ideas among family physicians from different countries and the training of family physicians throughout the world. The WONCA promotes the training of family physicians around the world. The International Center for Family Medicine (ICFM), based in Argentina, promotes training of family physicians in Latin America. Members of several national organizations of family physicians or general practitioners have worked actively to promote the development of family medicine in other countries. These organizations have included the Royal College of General Practitioners (United Kingdom, Australia, and New Zealand), the Canadian College of Family Physicians, the American Academy of Family Physicians (AAFP), and the

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U.S. Society of Teachers of Family Medicine. The Department of Family Medicine of the University of Texas Medical Branch at Galveston provides faculty development courses to Latin American teachers of family medicine. International exchanges of family physicians and the establishment and funding of an international center for the promotion and training of family medicine could allow colleagues to learn strengths of individual programs and promote mutual development, as well as to provide faculty development and technical assistance for many countries interested in training family physicians.

CASE STUDIES

The following case studies illustrate how family practice programs have been developed in three diverse health-care systems. All of the barriers listed in List 1 were encountered in each country. The strategies used to overcome them varied according to local circumstances.

SOUTH KOREA

Family medicine was introduced to South Korea in 1979. At that time, general practitioners were physicians with no postgraduate, or only internship, training, and more than 20% of specialty-trained physicians were estimated to be practicing only primary care.

The first family medicine residency program was started at the Seoul National University Hospital with assistance from an American consultant. Many early graduates became directors of similar programs in other institutions in the country. Family medicine has now become the fastest growing specialty in South Korea. Over the past five years, 38 new residency programs have been established, bringing the current total to 68. In 1994, family medicine residency programs selected 253 first-year residents, second only to internal medicine. Eighteen of the 35 medical schools now have departments of family medicine.

Family physicians practice in rural and urban underserved areas more frequently than any other specialists. Further more, clinical preventive services, sports medicine, and behavioral medicine are practiced almost solely by family physicians. Family physicians often appear in the mass media and are viewed by the public as forceful advocates of health education. This discipline became the first specialty to send undergraduate medical students to work with community family physicians during their clerkships. Also, family physicians have worked to incorporate concepts

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of oriental medicine into their practices, which is especially important in a country with a strong tradition of folk medicine.

The Korean Academy of Family Medicine now represents about 2,500 board-certified family physicians, and its members play an essential role in the national and international scene. In large part through the efforts of this organization, family physicians in South Korea have come to be viewed by the general public as friendly and responsive to community needs, and under the Academy's auspices, the 1997 WONCA Asia Pacific conference will be held in Seoul.

Four circumstances have been particularly important in the remarkable development of family medicine in South Korea. First, family medicine was introduced in the country's premier medical school by a highly respected physician, Dr. Chang Yee Hong. Second, in 1985 family medicine achieved the status of board certification and became the 23rd specialty in South Korea. Third, universal medical insurance mandated by the government in 1989 required that tertiary centers could see only patients who were referred from physicians in local clinics or hospitals. Family practice centers within the tertiary care centers were exceptions and could provide direct care to patients and refer those requiring specialty services. This policy encouraged tertiary care hospitals to establish new family practice departments. Fourth, family physicians have exhibited remarkable commitment and dedication to teaching and promoting their discipline among students and residents. Additional strategies have included grassroots promotion of community health education, development of a number of vigorous training programs, and leadership in international family medicine.

VENEZUELA

Primarily due to its petroleum industry, for most of the twentieth century Venezuela has been the wealthiest country in Latin America. In the 1970s and into the 1980s, the government sent many physicians to the United States and Europe for training. This contributed to the country's emphasis on subspecialty and tertiary care medicine. By the late 1970s, the country sought to improve its health-care system in response to national criticism and in response to information from other countries about the concept of "primary care." Since then, several key people, strategies, and events have contributed to the development of the specialty of family medicine as a model for primary care.

In 1979, Dr. Pedro Iturbe, an influential retired Venezuelan pulmonologist, decided that the country needed a new community-oriented model for health care delivery. He

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invited regional politicians and academic leaders to seminars about family medicine. Simultaneously, the Pan American Federation of Medical School Faculties in Caracas sent a group of health care leaders to visit the United States and Canada to learn about family medicine as a primary care model and a strategy for improving health care delivery.

With the financial support of the local government, in 1980 Dr. Iturbe recruited a Venezuelan physician and epidemiologist, Dr. Felix Gruber, to return to Venezuela after ten years of studying and teaching family medicine in the United States in order to start the country's first family practice ambulatory care center. The next year, Dr. Iturbe convinced government and private industries to underwrite the Venezuelan Foundation for Family Medicine (FUNVE MEFA), which continues to provide financial support for faculty and resident salaries, professional meetings, and publicity for the new specialty.

As Drs. Gruber and Iturbe were developing and promoting family medicine in Maracaibo, Dr. Carmen de Carpio began to promote this specialty in the capital city of Caracas, working within the Social Security Institute. In 1982, three residency programs opened simultaneously, two sponsored by state universities (in Maracaibo and Merida) and one by the Social Security Institute (Caracas). Family physicians were and continue to be trained to work in ambulatory care community-based clinics, with a specific goal of reducing the need for patients to be treated in hospitals. From the beginning, this ambulatory care focus reduced resistance from other specialties, and promoted their support of the new training programs. Mostly because of political lobbying by these three influential physicians, the Venezuelan National Medical Association formally recognized family medicine as a medical specialty in 1984.

To create role model clinician-educators, five young physicians with leadership potential were sent in the mid-1980s for training in family medicine programs in Canada, Mexico, and the United States. Later, FUNVEMEFA sent 12 other Venezuelan physicians to Puerto Rico for a sixmonth family medicine faculty development program. Many of these 17 physicians trained outside of Venezuela continue to be influential academicians in the country. In addition, Dr. Iturbe arranged for McWhinney's text, *Introduction to Family Medicine*, to be translated into Spanish. This Canadian perspective of the family physician is reviewed in detail and debated by small groups of new residents each year throughout the country.

The development of family medicine in Venezuela provides an example of how much influence a few leaders can have. By enlisting the support of influential local physicians, courting government and private financial support, and carefully

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identifying and nurturing leadership potential among the earliest-trained Venezuelan family physicians, Dr. Iturbe led the development of a network of effective and stable residency programs by the time of his death in 1993. There are now 11 family practice residency programs and over 500 residency-trained family physicians in Venezuela.

PAKISTAN

Pakistan is a developing country characterized by high levels of poverty (mean GNP per capita 380 U.S. dollars), illiteracy (75%), annual population growth (3.2%), and infant mortality (134 deaths per 1,000 live births). Only 55% of the population of 122 million have access to adequate primary health services, and two-thirds of all deaths are due to infectious diseases.

A government-sponsored national health-care system does exist, but funds are inadequate, as per capita spending on health is only about \$6 per year. More than 80% of the government's health-care budget is devoted to the funding of hospitals and less than 20% to primary care. Over 90% of all medical students are trained in 18 government-funded schools, and until very recently less than 5% of the medical school curriculum was devoted to primary care.

In 1985, the Aga Khan University, a private medical college, was established in Karachi with a commitment to train physicians able to address the health-care needs of Pakistan. The Department of Community Health Sciences leads in the teaching of community medicine, which comprises 20% of the five-year medical school curriculum. The ambulatory care clinical training of students is accomplished in a system of community-oriented primary care centers. A computerized medical information system was developed to track morbidity and mortality data at the centers. Using information from this system, which describes local disease patterns, physicians in the Department of Community Health Sciences and general practitioners in the community in 1989 developed a Diploma in Family Medicine examination, offered by the College of Physicians and Surgeons of Pakistan. Through this diploma, general physicians demonstrating high standards of primary care receive official recognition by passing the specialty examination.

In 1990, the first family medicine residency program was initiated in response to the perceived need for adequately trained family physicians who could serve as clinicians and educators. Visiting family physicians from the United States worked closely with Pakistani primary care physicians to develop training criteria that would address local health needs. Efforts at the level of the community, local medical school, hospital,

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and National College of Physicians and Surgeons of Pakistan were necessary to gain acceptance of the new specialty. Articles were published in national medical journals, and presentations were made at national meetings.

Initially, the residency had limited success until the specialty was accepted at a fellowship level by the Pakistan College of Physicians and Surgeons. Now residents believe there is a future for them. At a 1994 meeting on community-oriented medical education, participants called on the government to create a department of family medicine at every medical college in the country and to create positions in basic health units for diploma-level family physicians and positions in hospitals for fellowship-level family physicians. An established base at a leading medical school, recognition by the National College of Physicians and the Pakistan Medical and Dental Council, and government support have all aided the early stages of family medicine development in Pakistan.

CONCLUSION

The establishment of academic departments of family medicine and of the clinical specialty of family practice is vitally important to the realization of accessible, effective, and comprehensive primary health care. In order to enhance this process, it is first necessary to establish the need for well trained generalist clinicians among the leaders of medical education and the agencies promoting international and national health care development. Second, medical educators and health planners must understand the importance of an integrated plan for primary health care training and delivery, beginning in and extending beyond medical school into the medical workforce. Third, coordinated efforts should be made to share experiential knowledge gained from the establishment of family practice programs in other countries. Cross-national comparisons of countries facing similar concerns can be helpful. Fourth, as health care planners seek to implement the possibilities inherent in family practice they must both define the health parameters they most wish to affect by the establishment of family practice and assess how the medical and political environments within their countries can foster the development of family practice and monitor its effectiveness. In order to be most effective, family physicians must be trained to respond appropriately to the local health care needs of the patients and communities they serve. Finally, and perhaps most importantly, financing policies must value and reimburse primary and preventive care, and rewards and opportunities must be created to provide incentives for young physicians to become residency-trained specialists in family practice.

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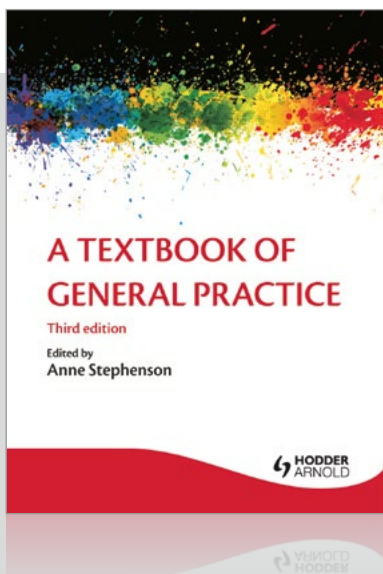
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In countries where there are no family doctors, the health care systems are dominated by physicians who are poorly equipped to practice high-quality, cost-effective, comprehensive, population-based preventive and curative primary care. The result is most often a fragmented and costly health care system focused on episodic curative care. By contrast, the front-line physician of a rational health system should be a well-trained generalist whose scope of practice encompasses curative and preventive services to the individual, families, and the community. While many nations still do not recognize the specialty of family practice, the number that do is substantial and increasing. In spite of the formidable barriers, we believe that the case is strong for the establishment of family practice as the basis of primary care in medical systems around the world. Family physicians as educators and role models are crucial for developing training programs in areas where there are no family doctors.

CHAPTER

2

PREPARING TO PRACTICE



This chapter is excerpted from
A Textbook of General Practice, Third Edition
By Patrick White, Ann Wylie, Anne Stephenson

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A placement in general practice offers opportunities for learning that are relevant to your development as a practising clinician whatever your final career choice. The variety inherent in the cases you will deal with should encourage you to look beyond the immediate case to the common elements; the thinking and learning processes you employ will be generally applicable to all types of medical practice. This chapter considers some of the practical ways in which you can use these opportunities.

LEARNING OBJECTIVES

This chapter is based around nine selected learning objectives, and springs from experience gained designing and running a course for senior undergraduates called 'Eight Weeks in General Practice and Primary Care', at King's College London School of Medicine.

By the end of this chapter you will be able to:

- adopt consultation and reasoning modalities appropriate to the clinical situation and the case;
- have good written communication skills;
- maintain good working relationships with members of a primary healthcare team and other agencies;
- show evidence of good timekeeping and organizational skills;
- implement strategies for managing uncertainty;
- operate within your own limitations and seek help when appropriate;
- accept and utilize constructive criticism, be willing to reflect on your own strengths and weaknesses, and act upon them;
- maintain sound professional conduct;
- adopt strategies for lifelong learning.

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INTRODUCTION

'I was able to work independently and had real responsibility for the first time in medical school. The GP had an excellent balance of allowing me to work independently and still being on hand if I needed assistance. This improved my confidence and made me more aware of the limitations of my knowledge.'

(A final year medical student)

The nine learning objectives consider aspects of your learning that are all achievable in the general practice setting, and are designed to be as relevant to those who will not eventually specialize in general practice as to those who will. The sections can be considered separately, but they do interrelate, and there are cross-references. Much of the activity leading to the achievement of these learning objectives is based in clinical practice (i.e. seeing and consulting with patients yourself, ideally in a separate room from your tutor but in close proximity, and with supervision and sanctioning of your decisions by your tutor). Reflection on your performance in those consultations will yield interesting and useful information, so we encourage you to keep a log diary of your clinical sessions. Reading the chapter, especially the thinking and discussion points and practical exercises, will indicate the sort of information you could record in your diary.

Log diaries can be updated between consultations with patients or by reviewing the notes at the end of a clinical session. Sometimes it is useful to use different techniques, recording immediately after a consultation is more influenced by the emotional impact of the individual consultation (an important factor that has to be considered in its own right), whereas recording at the end may illuminate how one consultation affected others in the same session.

Take opportunities to discuss more than individual patients with your tutor; consider how your performance is changing, evolving or getting stuck. Ensure you consider the big picture as well as individual scenarios; take opportunities to see common ground, similarities between patient scenarios or between management strategies, as well as the differences – this will enable you to generate ideas within a consultation even when the case itself is not one you have encountered before.

Don't worry, no one knows all the answers to everything, you are here to learn, and your supervisor will check your consultations. Try to use a problem-solving approach, to be prepared to justify your thought processes, and to safety-net and follow-up your patients.

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You will already have developed or be developing your own personal style. An aspect of this individuality is that we do not respond in the same way to patients, and some consideration of the impact different patients have on us as individuals is necessary so we understand how this can influence our decision making. These are good areas for discussion in one-to-one tutorials, or group sessions with your peers.

In group sessions, everyone is a source of information, expertise and views, and all contribute; you are all responsible jointly for each other's learning. Functions of group sessions may include:

- sharing individual experiences, learning vicariously about unusual presentations,
- sharing ideas of expected levels of competence,
- providing support for each other,
- debating difficult or sensitive issues in a protected environment,
- practising peer review and receiving constructive criticism,
- working collaboratively on a particular topic,
- practising skills through role plays and group discussion,
- recruiting expert support in certain shared areas of learning need.

THINKING AND DISCUSSION POINT

The general practitioner (GP) may know his or her patients well and over a long period. The apparent informality of this relationship might appear unusual to a learner; you might like to consider what the pros and cons of this might be. Where would be the best place to discuss this: with your GP tutor or with your group?

ADOPT CONSULTATION AND REASONING MODALITIES APPROPRIATE TO THE CLINICAL SITUATION AND THE PATIENT

ABOUT CLINICAL REASONING

Many learners coming into general practice from a hospital environment notice the apparently very different consultation technique, and the speed at which consultations occur. First, it is important to put aside speed as an independent goal – it is easier to learn to do the job well and then speed up than to learn to do it quickly and then get better. Second, is this technique really as different as it seems?

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Some words about clinical reasoning may shed light on this. Undergraduate medical students are taught to take a history, perform a physical examination and write up case notes with the differential diagnosis at the end, as though it could only 'appear' at that point. This linear model of thinking is known as inductive reasoning, which can be described as the completion of a comprehensive information-gathering programme before thinking begins (**Figure 2.1**).

Most experienced clinicians actually use a different model, hypothetico-deductive reasoning, which involves the postulation of a hypothesis during the consultation and the gathering of supporting or refuting evidence – sometimes known as 'guess and test' (**Figure 2.2**).

A necessary part of this thinking is 'pattern recognition', which depends on experience and which, at one extreme, may occasionally telescope the whole reasoning process (**Figure 2.3**).

Clinicians are able to use these models interchangeably, shifting emphasis according to the situation (**Figure 2.4**).

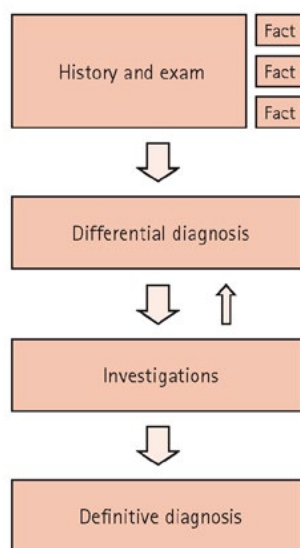


Figure 2.1 • Inductive reasoning

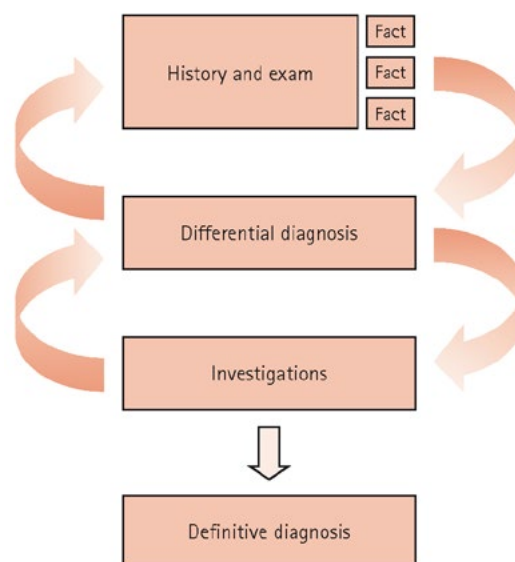


Figure 2.2 • Hypothetico-deductive reasoning

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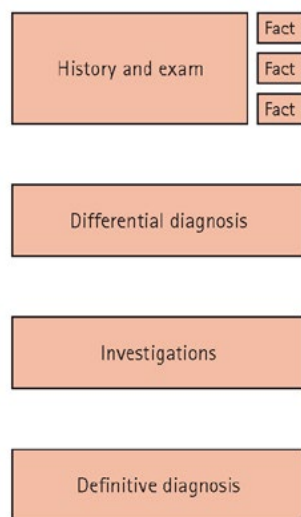


Figure 2.3 • Pattern recognition

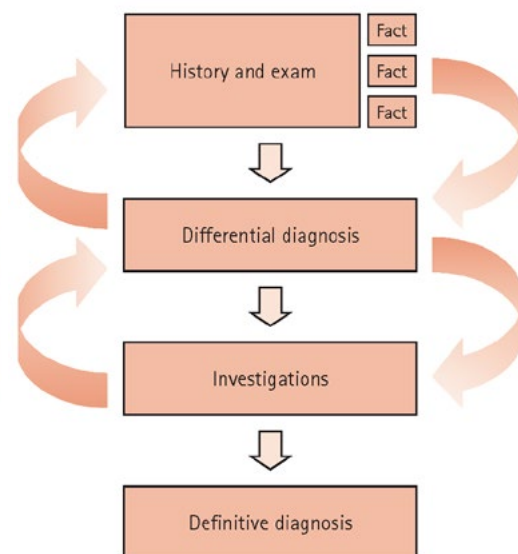


Figure 2.4 • A synthesis of clinical reasoning

Most trainee doctors use the inductive method, as it is thorough and tends to avoid error; experience makes it easier to use hypothetico-deductive reasoning. Different tasks can influence the reasoning approach used: the specialist must explore possibility, reduce uncertainty and marginalize error, so may make more use of inductive reasoning than the generalist, who explores possibility, accepts uncertainty and marginalizes danger. When diagnostic uncertainty is the reason for referral to secondary care, an inductive model is likely to be used, even by an experienced doctor, but many consultations in secondary and tertiary care, particularly in outpatients, are problem orientated and use a hypothetico-deductive base, just like the consultations in primary care.

The terms 'alarm symptom' or 'red flag' are often used to identify clinical features which need investigating (e.g. a cough with haemoptysis or abdominal pain with rectal bleeding). Whether or not a symptom gets 'red flag status' will depend on the patient's age, sex, lifestyle, etc. The recognition and response to red flag symptoms necessarily changes our consultation and reasoning processes.

THE INFLUENCE OF THE CLINICIAN'S PERSONALITY

Dangers lurk: there is an ever-present danger of fitting the evidence to the hypothesis, rather than the other way around – remember Procrustes and his comfortable bed.

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Procrustes lived alone on a busy route between two towns, and there were no hotels nearby. He would invite tired travellers to stay, but he was most particular that they fitted the spare bed exactly. If they were too tall, he cut off their feet, and if too short, he stretched them on a rack.

We are not machines; we have individual personalities and our own foibles, all of which we incorporate into our thinking. It may be useful to consider how we rank the list of our differential diagnoses. Several factors influence how we order the diagnoses we have considered.

- *Incidence* – age, sex, race, job, lifestyle, etc. This is hard information, not dependent on individual personalities.
- *Expertise* – have you heard of it? You cannot diagnose something you have never learned about.
- *Seriousness* – how threatening is it? We tend to give higher priority to those diseases that cause major harm, e.g. is it carcinoma of the rectum or piles causing this person's rectal bleeding?
- *Treatability* – do we have any treatment? Conversely, we are sometimes slow to confirm the diagnosis if it is one for which we have no treatment, for instance dementia or one of the degenerative neuromuscular diseases. This is an inevitable corollary of doctors' need to be seen to have a remedy.
- *Novelty* – 'I read a paper in the BMJ last week.' Things stick in our minds – recent articles, striking cases, or sometimes something we missed once and are determined never to miss again.
- *Bias* – 'I don't believe that chronic fatigue syndrome exists.' If so, you cannot diagnose it.

So how should all this influence how you conduct consultations as a learner in primary care? If a possible diagnosis occurs to you during the consultation, follow it up, look for supportive or refuting evidence, do the relevant physical examination. If not, follow the inductive model until an idea emerges. You should not expect to perform as fast as your tutor, and you will almost certainly not have as many well-known 'patterns' in your head as he or she does. Remember, your own personality colours your choices, so you may have to 'correct' for that, and, above all, remember that when you hear hooves, think of horses, not zebras – common things occur commonly.

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Practical Exercise

- Look at a list of patients you have seen in a morning surgery lately, and consider the diagnoses that you were concerned with. In how many cases did you order investigations in relation to diagnoses that were not actually the most likely but that you felt obliged to consider for other reasons. What were those reasons?
- How often were you able to shorten your consultation because the diagnosis became clear? How often did you perform a classical 'clerking' before you were clear what was happening?
- Repeat this exercise after a few weeks – reflect on any changes and the reasons for them.
- Compare your pattern with that of the partners in your practice, or with a fellow learner.

DEMONSTRATE GOOD WRITTEN COMMUNICATIONS SKILLS

In writing notes, a report or referral letter, it is important to consider the purpose, the reader and what they need to know. What should be included, and what left out? Do any ethical or legal issues need addressing?

THE PURPOSE

This may be to provide information to optimize future decision making: withholding sensitive information may impair the patient's future care if another doctor is unaware or does not think to ask for it, but including it relies on clinicians behaving non-judgementally. Another purpose may be to record decisions made and actions taken, including postulation of strategies and future care plans, with 'if, then' statements, especially if these have been negotiated with the patient. A further purpose is to enable self-audit and governance.

THE READER

The reader may be another doctor or healthcare worker. General assumptions about confidentiality and professionalism are beginning to be questioned here, and even now some confidentiality walls occur between, say, psychological/ counselling services and doctors, or between the genitourinary services and the rest of the National Health Service (NHS). Tension occurs between disclosure of unnecessary personal details and wish of some doctors to personalize the patient.

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Some written documentation is for patients or their non-medical advocates, for instance applications for housing or other social support, or for employment, insurance or other purposes. Assume this information will be dealt with by a non-clinician unless otherwise stated.

Recorded information may be for use by one of the governance agencies in audit and resource planning. Therefore, likely but unconfirmed diagnoses are better recorded as symptoms, for instance wheezing (instead of asthma) or chest pain (instead of angina), until the diagnosis is confirmed objectively; likewise, once the diagnosis is confirmed, you should code it correctly (see more about coding below).

INCLUSION/EXCLUSION

The question of relevance is all-important. A useful guide is the need-to-know maxim; that is, to do the job requested, what does the reader need to know? The problem is that you may not be able to answer that, but there are some safety nets. First, if the letter/report is accompanying a clinical situation, the patient can be asked to supplement the information, but you should ensure that information that the patient may not be clear about is in your communication (e.g. medication history). Second, you can indicate how the reader should contact you for supplementary information.

ETHICAL/LEGAL ISSUES

A few comments may help to identify the commonest issues, but this list is not comprehensive.

Remember always, patients can have access to notes written about them.

- *Non-judgementalism.* Your language must be non-judgemental. We all depend on our colleagues being non-judgemental as well; if we are not confident about this, we will be unable to write what is needed. It is allowable to make 'I statements' if materially relevant. For example: 'I find it hard to understand what this patient says', rather than 'This patient doesn't speak clearly'.
- *Consent to disclose.* This is particularly important if you are writing to a non-clinician. Alternatively, you can give the letter or report to the patient, allowing them to decide whether or not to pass it on.
- *Third-party interest.* In whose interest is the information to be used? It may not be your patient's. The best example is writing to insurance companies. The patient should have consented, but may not be aware of what he or she has consented to.

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Remember, insurance companies are not altruistic; they exist to make money for their shareholders.

- *Honesty and truthfulness.* There is an important but often misunderstood difference between these. You can be honest and untruthful ('I saw you at the park yesterday' – believing this to be the case, mistakenly) or dishonestly truthful ('I go running regularly' – not mentioning that it is only once a month; that is to say, hiding behind words). You should aim to be both honest and truthful.
- *Governance issues.* Some patients become anxious about information in their clinical notes being used for governance. Issues about agglomerated and anonymized information are still debated; society's unresolved dilemma about individual autonomy claiming superiority over the common good (e.g. 'not in my backyard') is a problem here.

ISSUES ABOUT FORMAT

With clinical record keeping now computerized, issues about format are more charged. For some time there has been wide variation in how notes have been kept 'traditional'/problem orientated (e.g. using 'SOAP' – subjective data, objective data, assessment, plan – headings for your notes), the use of personalized shorthand or cues etc. There is the additional problem of free text computer records being more problematic to search/analyse/audit than formatted or field-based records.

WHAT TO INCLUDE

Notes need to be brief, giving a summary of the history and examination, any important positive or negative findings, a record of any 'red flags' that are present or absent, your impression or working diagnosis, management plan, and an idea of your follow-up plan with safety netting. Safety netting is:

- What you expect to happen if you are right
- What you expect to happen if you are wrong
- What you would do in both these cases.

Many note recording systems use 'Read coding'. In the 1980s a GP, Dr James Read, developed a medical diagnosis coding system for use in general practice. It allows for audit trails and searches, and is almost universally used now when recording consultations electronically.

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Some referral systems now use pro-forma letters. These inevitably constrain the referring clinician, particularly around personalization, but they do prompt for relevant information that might be forgotten.

THINKING AND DISCUSSION POINT

How do you respond to the question 'Can I tell you something, but I don't want you to write it down in my notes?' What are the advantages/ disadvantages to the patient/doctor of agreeing to this request?

Compare your notes with those of your tutor, and consider the advantages and disadvantages of both.

Does the content (thoroughness, competence, etc.) of the referral affect the timing and confidence of discharge back? Does the referral affect the nature, tone, interest of the consultation itself?

Practical Exercise

With a fellow learner, each write a referral letter about a recent patient, then swap letters and read the other letter as though you were the specialist receiving the letter. Ask yourself, 'What am I being asked to do? Can I do this? What information is missing? Will the patient be able to supply it?'

DEMONSTRATE GOOD WORKING RELATIONSHIPS WITH MEMBERS OF A PRIMARY HEALTHCARE TEAM AND OTHER AGENCIES

You will also find material relevant in the chapters on general practice and its place in primary care and chronic illness. In most disciplines/specialties, doctors work within teams providing a mix of knowledge, skills and experience, personalities and approaches to care. Teams share caseloads, decision making and the uncertainty of working with patients, therefore providing a professional safety net.

Teamwork can be challenging; in particular, communication and mutual respect are key elements in a team's success. As with hospital multidisciplinary team meetings, primary care teams often meet frequently to discuss patients and plan their care. You should know about each member's role and responsibilities and how best to liaise with them. Sitting in and observing them at work is a valuable way of beginning to understand their work, but you should aim after a short time to take an active role.

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When working on the wards, planning a patient's successful discharge, you will find it very useful to have a practical knowledge of primary healthcare team members and community professionals – for instance, knowing that a speech therapist can be a vital help for someone with swallowing difficulties after a stroke. Understanding what services are really likely to happen in the community will help you avoid revolving-door readmissions, which are distressing for patients and relatives, and expensive and wasteful for the NHS.

Practical Exercise

Interview members of your primary healthcare team to understand their roles and responsibilities. Find out which patients they feel should be referred to them and which not. Ask for examples of good and poor team working, and consider whether you agree.

Practical Exercise

After you refer someone to another primary healthcare team member, discuss with them the referral from their perspectives.

SHOW EVIDENCE OF GOOD TIME KEEPING AND ORGANIZATIONAL SKILLS

Clinical work requires using time and resources efficiently. Importantly, before the placement begins, think about what you want to achieve by the end. Arrive punctually from day one, make a good impression and maintain that throughout the placement. These things form the evidence.

Figure 2.5 • An example of a system for setting priorities

	Important	Unimportant
Urgent	(Red)	(Amber)
Not urgent	(Purple)	(Blue)

SETTING PRIORITIES

First consider how you set priorities. One way is to use a system such as shown in **Figure 2.5**. You may need to set priorities within a consultation (e.g. the patient who presents a number of issues simultaneously) or within a session's work.

At the end of a morning surgery, you may have several activities to juggle – letters or emails, phone calls, discussing patients with colleagues, house calls, writing repeat prescriptions, having lunch or going to the loo. (Remember that the last two are important, as you may not function effectively if you are physically uncomfortable or hungry/thirsty.) Thinking about which tasks to perform, when and how long they will take, will help you plan the next few hours.

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ALLOWING TIME

Time expectations should not necessarily be the same for juniors as for seniors – you should expect to take longer over most consultations, letter writing, etc. If you get into difficulty, it is best to find a colleague to discuss it with or to ask help from. If you run constantly over time, it may be more appropriate to negotiate a different consultation period or insert frequent short breaks than merely to endure (and impose on others) the stress of running late.

MULTI-TASKING

Some people find multi-tasking easier than others. If you find it difficult, first acknowledge this to yourself and your supervisor, and adapt or find strategies to cope, such as taking more care with setting priorities and making sure others are aware of your working style.

COPING WITH DISTRACTIONS

Telephone calls and other interruptions occur continually. You need different criteria for allowing these, depending on whether or not you are the doctor on call. It is useful to have strategies for answering or deflecting requests for attention that do not offend or alienate the requester.

The opposite is important, too: how do you get and hold someone's attention without annoying them? It is useful to set ground rules with your tutor/supervisor about how you get their attention when you need it.

The way this learning objective is measured is primarily through in-course assessment, but don't forget that clinical examinations contain elements like coping with noise, time constraints, multi-tasking, prioritizing, etc.

THINKING AND DISCUSSION POINT

With your tutor/supervisor, discuss their criteria for managing interruptions and try to develop your own sets of criteria for different situations.

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Practical Exercise

Write a list at the end of morning surgery of tasks you have generated, and other tasks ahead in the day. Consider how you give them priority and whether that priority then remains fixed or continues to change as the tasks unfold.

Practical Exercise

With fellow learners, set up role plays of consultations interrupted by telephone calls or visitors. Practise the communications skills needed to deal with these both during 'ordinary' morning surgery and during a 'duty doctor' session. Get feedback from the people playing the interrupter and the patient.

IMPLEMENT STRATEGIES FOR MANAGING UNCERTAINTY

WHAT IS 'MANAGING UNCERTAINTY'?

Our response to uncertainty has to include both our thinking (the 'decisions') and our behaviour.

Although one might divide uncertainty in the clinical situation into diagnostic and therapeutic uncertainty, the former is commoner. When a doctor is uncertain what to do, it is usually because he or she does not know precisely what the problem is; management dilemmas occur less frequently.

DIFFERENTIATION BETWEEN UNCERTAINTY AND IGNORANCE/INCOMPETENCE

Because of the high premium put on knowledge both by society and by traditional medical education (and thus doctors), not knowing is easily equated with incompetence; this is much more in the doctor's mind than in the patient's. However, clinical problems present in a multitude of ways (as each patient is unique) and at a multitude of points in the natural history of the problem, so it may not be crystal clear to every doctor at every consultation what exactly the problem is. Consequently, handling uncertainty is the stuff of medicine, and general practice is where you can learn about it.

BEING A JUNIOR

Although we are all learning all the time, you are in the lucky position of being junior, so expectations should be lower, and asking for help should be easier. Also, you may

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have come to expect that most clinical situations can be resolved within the time frame of a hospital admission. Problems in general practice often continue to evolve over many consultations; even such things as childhood minor illness will evolve over time as the parents gain experience and confidence. The ability to decide what needs to be dealt with now, and what can be left, is often a major challenge to a young doctor, and depends on the ability to 'manage uncertainty'.

USE OF TIME – AS DIAGNOSTIC AID OR AS THERAPY

Time is one of the major tools in managing uncertainty. Time enables the problem to evolve, such that either new features appear, making a diagnosis easier or the problem resolves itself. Time may also show the effect of other factors on the problem – self-help, over-the-counter (OTC) remedies or symptomatic treatment – which may illuminate the diagnosis.

Here is an example of how time can be used to manage uncertainty. A youngster with colicky central abdominal pain, and some nausea, without very marked abdominal tenderness, may be seen by the GP, who advises symptomatic relief with fluids and paracetamol, suggesting 'a virus' or 'an upset stomach' as the cause. Indeed, many times this will be the case and the patient will recover; but the GP will know that, once in a while, one such patient will go on to develop the classic history and signs of appendicitis. Does the GP alert the patient and family to this possibility, or does he or she think this is harmful alarmism?

The patient may turn up in the accident and emergency department later saying, 'My GP told me it was an upset stomach', as the casualty officer looks incredulously at a 'barn-door' diagnosis of appendicitis! Alerting the family involves 'admitting' uncertainty, but is more honest, more likely to enable the family to seek further advice if needed, and more likely to nurture the GP's reputation.

PRACTICAL EXERCISE

In June you see a 15-year-old with a febrile illness and headache without meningism. What would you advise the patient and family? What difference does the time of year make?

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OTHER HELPING HANDS

This is all about safety netting.

- *Open door.* The security that the patient can consult again at short notice is a feature of general practice. This allows a sharing of responsibility between doctor and patient, relieving some pressure to sort everything out at one go. It places more of the locus of control with the patient, thus easing the doctor's responsibility.
- *Use of negotiation.* Discussing with patients the various options available not only shares some responsibility with them, but it may also articulate the choices for the patient and make the right decision more obvious. Patients may have views about how acceptable some options would be – our advocacy of an option unacceptable to the patient (i.e. lack of concordance between doctor and patient) often leads to a poorer outcome.
- *Appropriate goal setting.* We cannot assume that the endpoint of treatment we have in mind is the one that the patient shares. Some patients accept levels of risk that we might not; others might be looking for a goal beyond that which we can achieve with current medicine. Being honest and explicit about these things may help in setting shared, achievable treatment goals; this is another aspect of concordance.
- *Being explicit about expectations.* Distressed or needy people want answers; it is easy to fall into the trap of finding a superficially credible explanation or treatment simply to assuage the distress. It might be better to deal with the distress, acknowledge the need for answers, but honestly admit to the uncertainty. Disappointment and disillusionment may occur, but in smaller doses than if an expectation is created and subsequently not met.
- *Referral.* This could be from the GP to the specialist, but the same process occurs (and might be equally useful) in the case of the learner asking his or her tutor, the registrar asking his or her trainer, the assistant asking a partner, or one partner asking another. It might also be appropriate to ask a specialist from another discipline – nursing or therapy colleagues, for example. Saying you need another opinion is not necessarily a sign of intellectual bankruptcy, but more a sign of recognition of your own limits (see below).

DEMONSTRATE AN AWARENESS OF YOUR OWN LIMITATIONS AND AN UNDERSTANDING OF WHEN AND WHERE TO SEEK HELP

Central to the correct response to the awareness of one's own limitations is an honest view of what might reasonably be expected of you, and being open to feedback

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(see the section 'Accept and utilize constructive criticism', below). If you are not yet at the expected level of competence, some more learning is required (see the section 'Adopt strategies for lifelong learning', below).

Alternatively, you might be at the level of expected competence but be facing a problem that is outside it; this is normal for any clinician, whether generalist or specialist. Learning to respond properly is covered in the section 'Implement strategies for managing uncertainty' (above), but you do need to be able to seek help.

WHAT KINDS OF HELP ARE THERE?

- Written information, e.g. in a book or on the internet.
- Information or a second opinion from a peer/ colleague on site. This happens informally in hospital, on ward rounds, when discussions take place without anyone 'asking for help' explicitly. In primary care, discussions at the time, with a partner (or with the learner in the room!), at coffee time, or days after the event, when someone else has seen the patient for a further consultation, are all ways of getting help.
- Advice from a specialist source on or off site. Seeking advice either instantly or by appointment (a 'referral') is easily sanctioned. However, when making the referral you might consider not only the patient's needs, but also your own (can you learn something from this referral?).

Checking information should be acceptable, but some students or juniors (and some seniors) find it embarrassing to open the *British National Formulary* in front of a patient. Consider which is more embarrassing – looking in the *Formulary*, or discovering afterwards that you made an error in prescribing. The manner in which it is done is important: if you feel uncomfortable or embarrassed (arising from a misplaced internal expectation of 'knowing' lots) it will show, and the patient will naturally assume that you are justifiably embarrassed, and his or her expectations of you and your colleagues will simply increase. You are at a stage where it should not be embarrassing to check information, so you have the chance to set healthy behaviours for the future!

Telephoning a specialist registrar may be helpful; they may be flattered that their advice is being sought, particularly if you are seeking advice about how you might handle the problem, and not just handing over the patient to their care, without trying. Not infrequently, an offer of an outpatient appointment may then come easily.

Unless one is in single-handed practice, there are almost always fellow clinicians around. As a learner in a practice, you may only rarely witness your tutor ask a

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colleague, although you may see him or her being asked. The reason is that while you are there, your tutor already has a colleague on hand – you! Otherwise, it is not that unusual for one clinician to ask another, informally, for a second opinion, either at the time or later. Doing it afterwards provides a sounding board, checking out what one has decided, and also helps the next consultation.

As you are a learner, your tutor will almost invariably check the outcome of every consultation, but you may be uncertain about the physical examination or about what a certain part of the history signifies, and so the enquiry ('referral') would be about these things. You should not be reluctant to ask for this help, as without it you may make an avoidable clinical error (for which the tutor would be responsible), and you would not benefit from the learning that might accrue. It is really important to learn healthy ways of asking for help before you get to your early years as a junior doctor.

Doctors help themselves learn by reviewing their own performance, in audits, SEAs (significant event analyses), practice meetings, grand rounds, etc.

PROBLEM AREAS

For some people, asking for help with their skills can be easier than asking about knowledge; the techniques are the same, so whichever you find easier, apply the same technique to the other. It is often harder to ask for help if one's attitudes are causing problems, not least because these may be more difficult to see in the first place, and more difficult to admit. Sometimes people think that their attitudes are private, part of 'them', and therefore not on the agenda for change. However, our attitudes can affect our behaviour, and if this causes a problem, we must change it, even if we continue to hold our private underlying beliefs.

Asking for help when one is ill can be harder, particularly if help-seeking behaviour is not securely established. Doctors not infrequently fail to take time off when they are ill, and sometimes treat themselves (though this is unprofessional). Guilt about increasing our colleagues' workloads, and deeper seated beliefs about showing vulnerability, deny us the time and space we need, and that we would advise for our patients. This can lead to clinical mistakes, and can contribute to burnout.

One area where doctors are out of step with other professions is supervision. Nurses belong to supervision groups, and practitioners of almost any kind of talk therapy have a supervisor; but most GPs do not. Some GPs join peer-support groups as an informal form of supervision.

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PRACTICAL EXERCISE

During or at the end of one morning session, look back and ask yourself what, if anything, caused most difficulty in the consultation. Was it something you didn't know? Something you couldn't do? Or something about yourself that 'got in the way' (i.e. your knowledge, skills or attitudes)? Make a note and discuss with your tutor how to deal with these learning needs. Reflect on how you would do this if there were no 'protected' time for supervision in your timetable, and/or how you might set this time up.

ACCEPT AND UTILIZE CONSTRUCTIVE CRITICISM, BE WILLING TO REFLECT ON YOUR OWN STRENGTHS AND WEAKNESSES, AND ACT UPON THEM

CONTEXTUALIZING YOUR OWN PERFORMANCE

As doctors in training, we need to identify whether our performance is above or below expectations, and to consider whose expectations those are and how realistic they are. You may appear to be asked to perform the same task as in previous firms or attachments, and not consider that a higher standard of performance or a greater assumption of responsibility is expected of you. Conversely, a tutor may sometimes overlook the fact that you are not yet a registrar. Try to discover the standards expected of you at your summative assessment.

Using methods of self-assessment may also be helpful, and the RIME model provides a helpful framework for the senior undergraduate years, and beyond.

- *Reporter* – acting as the patient's mouthpiece
- *Investigator* – thinking about tests, referrals, etc.
- *Manager* – thinking about treatments
- *Educator* – thinking about explaining to patient/ peers.

Use this model to think about how, for a series of patients, you may take on several different roles, and how the prevailing role changes with time.

Another method of self-assessment is to notate your learning objectives with confidence ratings, comparing week-on-week or month-on-month improvements in confidence.

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OBTAINING AND LISTENING TO FEEDBACK

Direct feedback on your performance can be incredibly helpful when it is expressed in a constructive way that you can hear, accept and use to change what you have been doing. It might sometimes contain direct suggestions about what you might do instead, although ideally without any element of obligation. It is entirely appropriate for you to ask for this kind of feedback.

One thing that many doctors in the UK find hard to accept is praise – often it is met with embarrassment and internal disbelief; as such it is not ‘useful’, though what needs to change here is the attitude of the recipient. It seems to be part of the medical mind-set that praise is base currency; perhaps, if punitive criticism were less the norm, praise could be rehabilitated.

It is important to accept criticism in a constructive manner. By unlinking criticism from judge-mentalism, one can ‘hear’ it, consider its truthfulness, accept it and act on it.

USE OF RECORDING

This can be a powerful adjunct to another’s critique: you yourself are the observer and can see your own performance. It can be challenging, sometimes disturbing, even embarrassing, but it can also be powerfully affirming. Video is ideal, but audio is useful and may be technically easier to achieve; patient consent is essential. Suitable guidance and a downloadable consent form are available from the General Medical Council.

PERSONAL REFLECTION

The biggest obstacle to personal reflection is the allocation of protected time. Since it appears to be entirely selfish, it is often demoted in importance, but it is vital to the preservation of quality.

Some learners are uncertain how to reflect. The process is quite simple and unthreatening.

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PERSONAL EXERCISE

Think about something you have experienced.

- Start by writing down what actually happened; consider what you felt confident about and what you felt uncertain about.
- How did it make you feel?
- What do you think other people felt?
- What did you learn?
- What might you have done differently?
- Draw up some action points to work on so you can feel more prepared for the next time.

Aids to reflection may help: using open question sheets, generating lists or writing full significant event analyses. The process should embrace honesty, both in the narrative and, ideally, also in the emotional underlay (the reflector's emotions).

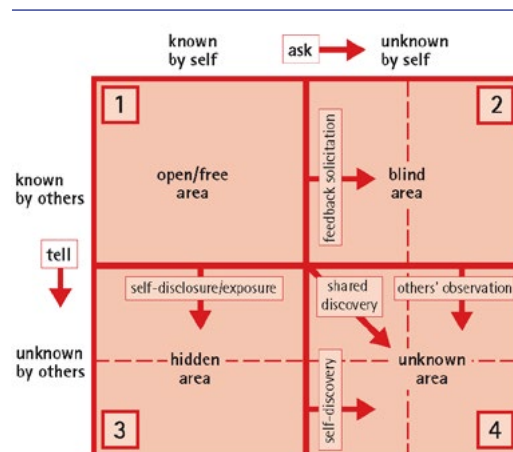
There is an important link here with the use of a portfolio (see below), which aids reflection as well as forming a record of evidence.

JOHARI WINDOW

Feedback, self-assessment and reflection on our work can illuminate issues that we wish to develop or change. However, problems can arise if we are unaware of or wish to hide some of our weaknesses, deficiencies or 'black holes'.

The Johari Window, named after its developers, Joseph Luft and Harry Ingham, shows clearly the various states of self-knowledge (Figure 2.6). The idea of self-assessment, feedback and reflection is to expand the 'open' box and minimize the other boxes. If you and your tutors become more aware of your problem areas, you are in a better position to change them. The relationship between learner and tutor can play a

Figure 2.6 • The Johari Window.
This version Alan Chapman 2003
www.businessballs.com



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central role in expanding the open box. A trusting and supportive relationship can provide a safe environment in which to discuss sensitive issues.

NEED FOR CHANGE

There is an active process that precedes change happening: first an acknowledgement that things are not right, and second an acceptance that change is necessary; this is akin to the shift from preconceptual to conceptual thinking with which you may be familiar in the context of behaviour modification.

GROUNDING

Key to knowing how much change is necessary is having an understanding of expectations (see the section 'Demonstrate an awareness of your own limitations', above). Being grounded with your peers is of inestimable value; in this context it means having an understanding of what your peers are able to do in similar situations, and having similar expectations of yourself. The best way of being grounded with peers involves, either formally or informally, some kind of small group activity, such as:

- undergraduate seminars,
- journal club,
- significant event analysis discussion,
- half-day release groups,
- young (or mature) general practice principals groups.

In discussions, you will gain an idea of where the common standard of competence is, and be able to establish whether that standard is sufficient for the expectations of your course/job.

Practical Exercise

At the end of the week/course, think back over what you have seen, experienced and learned. Use one of the suggested Thinking and Discussion Points, or generate your own.

Practical Exercise

Evaluate your RIME score for the last ten patients, and consider how you would have improved your score in each case. Re-evaluate your score a week later.

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THINKING AND DISCUSSION POINT

Reflect on the consultations you have undertaken on your own.

- Which one has affected your own personal thoughts and feelings most?
- Why did it affect you?
- What did you learn about yourself from this experience?

THINKING AND DISCUSSION POINT

Reflect on your learning experience in general practice.

- What would be the one most important point of feedback you'd like to give to your tutor/supervisor?
- What have you learned in this course that has changed or consolidated your approach to medicine?
- What do you perceive are areas of weakness that you have not addressed on this course and would like to build on in the future?

MAINTAIN SOUND PROFESSIONAL CONDUCT

It is recommended that you read the guidance on good medical practice on the GMC's website. In particular, you must know the duties of the doctor that the GMC has defined:

'Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must:

- Make the care of your patient your first concern
- Protect and promote the health of patients and the public
- Provide a good standard of practice and care
 - Keep your professional knowledge and skills up to date
 - Recognise and work within the limits of your competence
 - Work with colleagues in the ways that best serve patients' interests

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- Treat patients as individuals and respect their dignity
 - Treat patients politely and considerately
 - Respect patients' right to confidentiality
- Work in partnership with patients
 - Listen to patients and respond to their concerns and preferences
 - Give patients the information they want or need in a way they can understand
 - Respect patients' right to reach decisions with you about their treatment and care
 - Support patients in caring for themselves to improve and maintain their health
- Be honest and open and act with integrity
 - Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
 - Never discriminate unfairly against patients or colleagues
 - Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.'
(General Medical Council, 2011b)

You will already notice how many of these resonate through the subjects of this chapter. Getting feedback is essential for monitoring your behaviour, informally, or formalized in ways like a 360-degree appraisal. Keeping a reflective diary is a way of self-monitoring. At all times, remember attendance is a proxy for commitment, and punctuality for reliability.

ADOPT STRATEGIES FOR LIFELONG LEARNING

PURPOSE

Why is lifelong learning important? Medicine is changing and developing rapidly; you cannot expect your present knowledge to be up to date for long. As professionals,

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we have a responsibility to keep up to date to ensure we provide good care to our patients (see also the previous section on the GMC's guidance on good medical practice). We need to be safe practitioners and analyse and learn from our mistakes; to enjoy our work, we need to remain enthusiastic by stimulating our own interest. The public, through our governing body the GMC, needs to be assured that we are maintaining high standards of care: annual appraisals with revalidation every 5 years in the UK is now the norm. Doctors need to meet an established minimum competence level to be relicensed to work in the NHS in the UK.

As learners and doctors, we must ensure we continue to learn and to develop strategies on how best we learn so that this learning is sustainable throughout our careers.

Figure 2.7 • Kolb's cycle



WHAT IS IT?

Incorporating adult learning principles is important for lifelong learning and continuing medical education.

Adult learning is deciding what we want to learn and using our past experiences. What we learn needs to be relevant to what we do in everyday practice, so that we improve patient care. It involves:

- Identifying strengths and weaknesses: being able to say, 'I don't know about this'.
- Reflection (Kolb's cycle): putting learning into action is very powerful, confirming the value of what you have learned and stimulating ideas on what else you would like to learn (see [Figure 2.7](#)). There is more on reflection in the section 'Accept and utilize constructive criticism', above.
- Setting realistic objectives and goals for yourself.

Lifelong learning is key to our professionalism, and a crucial part of this is the ability to reflect on practice and learning.

HOW TO DO IT

There are many different ways that we can keep up to date. Some activities will suit you, others will not:

- Update sessions/courses can be useful, but may not always meet your needs.
- Journals and journal clubs: sharing information with peers includes grounding yourself and setting realistic standards of care in your practice or department. This can be a useful way of providing consistency of care within a team.

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- Electronic information is available while you consult, and can be shared with the patient; many websites are available.
- Patients are an invaluable resource, particularly since the advent of the internet. Some doctors feel challenged by well-informed patients (does this threaten the role as keeper of 'secret professional knowledge'?) but actually we have the very important role of helping the patient understand how relevant/complete/accurate the information is.
- Developing a special interest or responsibility within a team will necessitate you keeping up to date and being a resource to others.
- Keeping a log: we often come across areas of medicine that we are unsure of. By keeping a log of things to look up when seeing patients and following up what we are unsure of, we learn 'on the job'. Try not to be intimidated doing this in front of patients – it is much better to feel sure you are doing the right thing.
- Peer groups offer support and an opportunity to reflect on your own practice, and set this in the context of the practice of others at your level (see also the section 'Accept and utilize constructive criticism', above).
- Correspondence from colleagues can be a useful way of learning up-to-date management approaches.
- Asking for advice and help from a colleague is a common method used when there is uncertainty in clinical decisions.
- Television/media: hearing something on the news or even in a television soap can often be a learning point for us or to help us to understand patients' thought processes.
- Developing a portfolio (see below).

PORTFOLIOS

These are increasingly prevalent in medicine but are common in other professions. Nurses have been using them for a number of years for continuing professional development and accreditation. They originate in graphic arts and consist of a collection of evidence that shows learning has taken place.

The learner decides what goes into the portfolio. Seeing a patient with a particular illness may spark your interest in finding out more about that illness; when faced with a clinical problem that you are unsure about, you can use the opportunity to include what you learn in your portfolio. The portfolio uses your clinical experiences as the starting point for your learning, so that when you next see a patient with a

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similar problem you are more confident managing them. It is relevant and usable for future clinical practice.

The portfolio's success depends on how much effort and time goes into it. Be careful not to embark on huge projects that become unmanageable. Try to be specific (e.g. instead of writing about 'ischaemic heart disease', consider focusing on, 'the pharmacological treatment of angina').

Reflecting on experiences is central to developing a portfolio. When thinking about clinical encounters, identify strengths and weaknesses – areas where you feel confident or unsure. Think of strategies you can use to learn about the areas you do not feel confident in (e.g. read a review article, go to an outpatient clinic, speak to a specialist, read a book). Then write about your learning and how it may affect your clinical practice in the future. For example, studying the management of urinary tract infections in general practice may increase or decrease your requesting of midstream urines, or your referral rate, etc. Thinking about your learning can spark ideas of other areas you would like to learn more about, which you can include in your portfolio.

It can also be useful to think about how you learnt: did you learn more by reading an article, going to a presentation, or discussion group? This helps you identify how best you learn, which should make it easier the next time.

Sharing your portfolio with a tutor or peer may be useful, particularly when discussing what and how you have learnt.

Portfolios can replace formal examinations as a form of assessment. Some medical schools have replaced the traditional final examinations with a portfolio that students develop in their final year. The advantages of a portfolio as a form of assessment include the following:

- A portfolio can assess areas not easily assessed by other methods, particularly professionalism, because the ability to reflect is a key component of professionalism. This is useful, given the push from the public and the GMC to ensure professional standards are met at graduation and postgraduate levels.
- Portfolios are authentic; they can chart what the learner actually does over a period of time. Multiple choice questions (MCQs) are useful for assessing knowledge, and objective structured clinical examinations (OSCEs) assess 'shows how', but this may not be what the learner actually does daily in practice when seeing patients.

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MAKING A HABIT OF IT

It is our professional responsibility to remain up to date and skilled in our area of medicine. To learn effectively, we need to use strategies that suit us so that we can sustain our learning throughout our career.

PRACTICAL EXERCISE

Set your own learning objectives and start your portfolio; complete a self-assessment exercise or a reflective journal.

PRACTICAL EXERCISE

Write down how you found out about something you were not sure about – books/colleagues/internet.

SUMMARY POINTS

Things you learn while you are in general practice are useful whatever you do in medicine. To conclude, the most important messages of this chapter are as follows:

- Being aware of how you think and make decisions helps improve how you consult with patients.
- Reflective learning is easy and helpful.
- Fostering and maintaining relationships with colleagues is crucial to clinical team working.
- Organizing your time and resources helps in your working day.
- Being honestly self-aware is healthy and productive.
- Feedback from peers, colleagues and patients is a valuable resource.
- There are a multitude of ways to keep learning.
- Productive learning is satisfying and fun (Figure 2.8).

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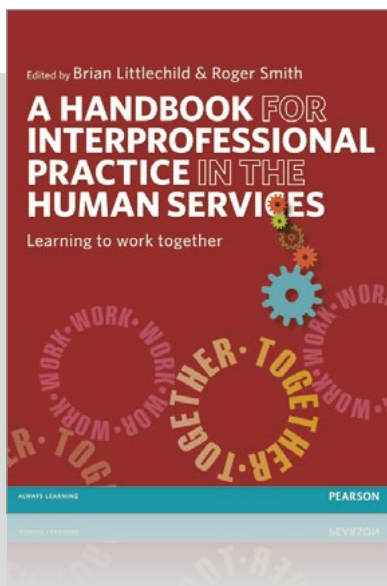
Figure 2.8 • Learning can be fun.



CHAPTER

3

WORKING TOGETHER: WHY IT'S IMPORTANT AND WHY IT'S DIFFICULT



This chapter is excerpted from
Interprofessional Practice in the Human Services

By Brian Littlechild, Roger Smith

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WORKING TOGETHER: WHY IT'S IMPORTANT AND WHY IT'S DIFFICULT

Roger Smith

Excerpted from *A Handbook for Interprofessional Practice in the Human Services*

CHAPTER SUMMARY

This chapter aims to introduce a number of key aspects of interprofessional or collaborative working, in order to focus specifically on the opportunities and challenges presented. It first identifies some of the benefits as well as potential disadvantages associated with working together. Building on this framework, the chapter proceeds to discuss the underlying preconditions and the practice requirements necessary to ensure that collaboration is effective, and of fundamental importance, and actually works to the benefit of people who use health and social care services. In setting out these elements of good practice, however, there is no attempt to hide or minimise the kind of interpersonal, professional and structural obstacles which stand in the way of successful cooperation.

LEARNING OBJECTIVES

This chapter will cover:

- the origins of interprofessional working
- the potential advantages of collaboration
- potential shortcomings in collaborative practice
- the challenges and opportunities of joint working
- key elements of effective collaboration
- the value base for working together

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A CLOSER LOOK

Why should we work together?

Victoria Climbié died as a result of extreme abuse and neglect on 25 February 2000, aged 8. One of the witnesses to the subsequent inquiry into her death described it as 'the worst [case] I have ever dealt with, and it is just about the worst I have ever heard of'.

Writing about the lessons learnt from Victoria's history of abuse and the inadequate responses of a range of agencies and professionals, the president of the Royal College of Paediatrics and Child Health wrote: 'Prevention depends on collaboration . . . [I]t is not just organisations, committees and boards that must work together. Children like Victoria die when individual professionals do not work together.'

STARTING FROM THE BEGINNING

The impression is sometimes created that working in partnership has only become recognised as an important aspect of professional practice relatively recently. It is certainly the case that books such as this, and other publications on the subject, have only been produced in any quantity in the past decade or so. This does not mean, though, that the move towards better mutual understanding and cooperation in practice has no significant history. In fact, it is more likely that collaboration in some form or other has always been the norm as the modern welfare state has developed. This is certainly the view of some of those who have commented on the subject previously. Pietroni, for example, has suggested that 'The development of "groups of workers" coming together to look after a patient began with the emergence of the hospital'. As health and social care provision began to be developed as a systematic form of activity, so there also emerged an increasing number of specialised roles and tasks. While at first the interface between different specialised functions may have been highly structured and regulated, the 'militarisation' of medical services meant that tasks and relationships between practitioners also came to be differentiated and closely specified. This also ensured that services tended to be organised in a hierarchical fashion, with little scope for mutual negotiation or exchange of professional opinion. But what it did mean was that even from this early stage the need for specialist skills, systematic allocation of tasks and effective communication and 'transfer' arrangements was recognised quite clearly. Ironically, in fact, the gradual development of very specific functions in health and welfare also led to a parallel requirement for those carrying out

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these functions to share responsibilities and develop effective ways of combining their inputs in the interests of service users/patients.

The process of specialisation has sometimes been equated to the equivalent developments in industrial production and other commercial spheres. The pioneer of this kind of approach is believed to be Frederick Taylor, who was driven by the perceived need to improve the quality, productivity and efficiency of manufacturing processes. Taylor believed that complicated activities could be broken down into a series of relatively straightforward tasks, which could then be streamlined and integrated to maximise overall performance. Whether or not it has been motivated by exactly the same logic or demands, the same kind of trends have been identified in the welfare sector, with a similar increase in the number and range of specialised activities. However, it is also acknowledged that a simple transfer of lessons from industry to health and welfare may be to underestimate the inevitable complexities of human services:

While it is fairly straightforward to look at outcomes of a discrete condition or stage of care (situations where specialists tend to perform better), it is much harder to do so for patients with a variety of acute and chronic illnesses cared for in different settings for an extended period.

There have been other drivers, too, that have created an increasing variety of professional identities, with responsibilities which may only be effectively discharged if they are linked with the work of others. Of course, this trend has partly been about the search for a distinctive rationale, value base and identity which has occupied the thoughts of many practitioner groupings, especially those which have been established as distinctive occupational roles relatively recently (the 'new' professions).

Exercise 3.1

Can you identify and distinguish separate lists of 'old' and 'new' professions in health and social care? Looking at these two lists, what are the features which differentiate them? Do you think these differences might lead to tensions and conflict?

This in turn itself sets up some interesting and challenging dynamics, given that becoming effective collaborators might mean giving up some aspects of your autonomous standing, which may have been hard won over a period of time.

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At the same time, difficulties 'can arise over the use of the word "professional"'. If other practitioners, or non-professional interests and viewpoints are marginalised by this use of terminology, purely because they do not see themselves as 'professionals', genuinely collaborative working may also be made more problematic. This issue becomes more significant still when we reflect on the importance of keeping 'carers' and those 'cared-for' at the centre of the process, and seeing them as key members of the 'team'.

So, two distinct trends of specialisation and professionalisation have been increasingly influential in shaping the working environment in health and social care. As tasks have become more discrete, and to some degree routinised, so have those responsible for carrying them out sought to articulate and maintain their own standing as professional experts with a degree of autonomy, authority and discretion. In light of this, it is perhaps not surprising that there has been an emerging recognition of the tensions and barriers inherent in these changes, and the need to address them. This has certainly been recognised as a significant challenge in the world of policy and practice guidance for some time, an awareness which has been compounded by the recurrent evidence from major inquiries that a failure to collaborate effectively may amount to risky and, indeed, harmful practice.

A CLOSER LOOK

Finding common ground

When I was asked to join a youth diversion team comprising a teacher, a police officer, a social worker, a youth worker and a probation officer, it quickly became clear that we had to find a balance between representing our own agency and its working principles and combining to deliver the specific collaborative task for which we were responsible. In order to do so, two essential preconditions had to be met. We all had to be prepared to give up some areas of practice for which we might previously have claimed exclusivity, and we all had to be ready to accept the validity of other disciplines' distinctive skills and expertise.

Against this backdrop, then, there is a definite sense that the priority accorded to collaborative working has been enhanced in recent years, and that it has come to be seen as the starting point for effective practice in many areas across the service spectrum, rather than an optional extra. This impetus has been supported by many examples of 'good practice', such as the present author's own experience

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of multiagency juvenile diversion, or the evidence from collaborative rehabilitative interventions for older people.

In parallel with these developments 'on the ground', we have also seen considerable behind-the-scenes activity on the part of government and other policy making bodies. It has become almost a matter of faith that collaborative working is desirable and has the potential to resolve many of the difficulties encountered by people who feel that they are let down by health and social care agencies. But it is as well to begin with a cautionary note, as sounded by an earlier commentator:

What remains to be seen is whether the pressure on health and welfare professionals to work together will have a positive outcome . . . will clients, patients and users receive quality care and be enabled to make choices on a meaningful basis? Or will professional identities, under the cloak of rationalization and skill mix realignment, become diluted and the standards of care undermined? Time will test the interprofessional resolve.

In light of this observation, it is worth stressing that in order to be able to work well with colleagues from other disciplines you will need to have and hold a clear and confident view of your own profession's purposes and principles.

GAINS AND LOSSES 1: POSSIBILITIES

As in almost any sphere of activity, collaboration in health and social care presents both opportunities and risks, and has always done so. It has been relatively easy to make a case for partnership in recent times based on the observable consequences of fragmented services and poor communication, but it may be that pressure to find easy solutions and 'quick fixes' has led to an underestimation of some of the endemic difficulties involved. As suggested elsewhere, a number of both advantages and disadvantages are attributed to working collaboratively. On the positive side of the coin, we might expect improvements in the following areas:

- **Improved efficiency.** There are a number of essentially practical ways in which sharing arrangements to work with service users should make provision more accessible and efficient. Thus, for instance, a number of discrete resources may be accessible to users from a single point of delivery. At the same time, practitioners may find that it is easier to communicate, and to share information

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and referrals with colleagues from different disciplines where they work from a shared working environment, or under the aegis of a common 'team' identity. It may be the case, for example, that recent trends towards offering combined mental health services have proved beneficial in this respect. Some of the challenges of working across different service boundaries, and negotiating competing policies on issues such as confidentiality and sharing records, may be reduced under this sort of arrangement.

- **Better skills mix.** Similarly, the capacity to offer a broader range of skills may be a direct consequence of collaborative working strategies. In an increasingly specialised world, practitioners very often feel that they are being asked to undertake tasks at the limits of or beyond their own levels of competence, and which they have not been trained to undertake. In such instances, the scope to be able to draw on the expertise of colleagues and to integrate these into the overall service on offer may be very valuable. Police officers, for instance, have often been heard to complain that they have to act as social workers in crisis situations. Models of practice which facilitate closer working between the two might well go some way to alleviating this kind of frustration. Additionally, the availability and use of other sources of expertise may also contribute to a recognition of each other's specific knowledge and competences, reducing levels of suspicion or mistrust.
- **Greater levels of responsiveness.** People who use services are themselves often frustrated by the partial or inaccessible nature of the responses to their felt needs. Services which adopt a collaborative approach should be able to alleviate this concern in a number of ways. Firstly, it should be possible to 'signpost' someone to the relevant specialist service more easily. Secondly, practitioners themselves should have a better sense of what is on offer, and thus be empowered to make a greater range of options available. And it should be possible to tailor service mechanisms, such as assessment procedures, to address a variety of potential needs. This is clearly the intention of policy innovations such as the Common Assessment Framework for children; logically, common assessments also need to be linked to a suitable menu of interventions depending on the needs and aspirations identified.
- **More 'holistic' services.** Service users often find it irritating and confusing to be told that different providers will be responsible for different aspects of their 'problems'. At the same time, there is clearly a risk that atomised services will only address one aspect of need, while regarding anything else as 'someone else's job'. A holistic approach enables more facets of a complex situation to be addressed in tandem and in ways which complement each other. For instance, for disabled people this might mean that what they see and experience as arbitrary

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distinctions between medical and social needs can be eliminated and integrated services provided which bridge these divides. (See **Figure 3.1.**)

- **Innovation and creativity.** Not only does collaboration offer the possibility of a more rounded approach, it may also generate a creative environment for innovation. Where practitioners are able to share ideas and approaches, they may well gain fresh insights and feel enabled to exercise their imaginations. There is also the possibility that roadblocks arising from the constraints imposed by one organisation or procedure may be open to negotiation or circumnavigation when representatives of other agencies become involved. The involvement of other agencies in the juvenile diversion project in which I worked some time ago enabled the police to be much more confident about exercising their discretion and pursuing alternatives to prosecution.
- **Greater likelihood of user-centred practice.** It may be felt, too, that the experience of working together in the interests of service users can have an impact on organisational dynamics. Practitioners may indeed find the focus shifting because their interventions are organised around the service user, rather than along lines predetermined by the agency. By centring the service user in this way, collaborative practice may be seen as having the potential to empower user and practitioners alike, as they seek to reframe services so that they are tailored to individual needs and circumstances. The original intentions of person-centred planning seem to represent a manifestation of this principle in policy and best practice guidance.



Figure 3.1 • The team around the disabled child

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There is thus considerable potential for collaborative practice developments to change some of the dynamics of intervention, by breaking down arbitrary distinctions between different aspects of service delivery and agency responsibilities. Such developments may also, by their nature, be more likely to place service users at the centre of processes of assessment, planning and intervention; and this, in turn, may lead to a greater sense of freedom and creativity for the practitioners concerned. These, then, are some of the positive aspects of interprofessional working.

GAINS AND LOSSES 2: PITFALLS

On the other hand, we might still expect a number of recurrent problems to arise. These may not be exclusive to interprofessional working, by any means, but they may become more acute in this context. Working towards collaboration may well be an uncomfortable experience for those involved, and they may feel at times that they are not fully supported in the pursuit of this aim by agencies which are also competing for resources and status:

- **Boundary disputes.** One of the issues likely to emerge in any attempt to establish effective interprofessional working arrangements is the nature and extent of each partner's role and responsibilities. This is especially the case because most professions, including those with long and established traditions, have a limited and unclear view of their own boundaries; what is or is not 'my job' may be a difficult question for many involved in partnership working. As a result, two opposing problems may arise: some tasks, especially those which are seen as particularly problematic, may be shunned, for example. On the other hand, certain aspects of the combined function may be the subject of 'colonisation' attempts, whereby one professional group will lay claim to an exclusive role at the expense of others. These tensions illustrate another important consideration for collaborative practice: that is, to achieve a fully integrated approach, joint teams must go beyond simply sharing out tasks and begin to adopt principles of collective responsibility and accountability.
- **Status issues.** Bringing diverse practitioner groups together with their different traditions and mutual expectations is almost bound to raise status issues. Unequal standing is probably manifested in a number of ways, some of them quite tangible. A simple look round the car park will probably bring this observation into sharp relief! The tension between the notion of an equal partnership and the traditional hierarchies sketched out by Pietroni is perhaps inevitable. It can materialise in a number of ways, including the assumption by some participants that they are able to instruct others, on grounds of professional expertise rather

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than organisational position, as opposed to working with them to agree collective solutions. Lymbery, likewise, has suggested that 'the uncertain professional status of social work creates a particular problem in relation to the development of collaborative working' with older people.

- **Language barriers.** As we have already observed, the difficulty of agreeing a common language is quite fundamental, starting with the long-running debate about how we should define the people with whom we work: are they 'patients', 'service users', 'clients', 'customers' or just 'citizens'? Beyond this, though, is a more extensive concern about the ways in which language structures professional identities, assumptions and practices. It is undoubtedly the case that the development of specialist terminology and shorthand (especially acronyms) is associated with the perceived need to establish professional identities and credibility. On the other hand, however, it is also well documented that such use of language can be exclusive and divisive, both between practitioner groups and between providers and service users. This is not to suggest that no such terms or forms of use are appropriate, just that the impact of their applications must be borne in mind and moderated as far as possible.
- **Competing practice models.** Lying behind differing language practices may be more substantive differences in the ways in which people who use services are defined, their problems identified and interventions constructed. One of the most obvious of these is the apparent opposition between 'social' and 'medical' models in work with people with disabilities, or those who have mental health needs. Similar, perhaps less clear-cut oppositions arise in the field of criminal justice where young people who offend can be defined first and foremost as 'criminals', or, on the other hand, as having welfare needs which should be prioritised. Such differences of perspective obviously have very substantial implications for the ways in which practice is organised.
- **Complex accountabilities.** In the midst of the potential differences between professional groupings outlined previously, there are also likely to be complicating factors arising from structural and organisational tensions. Where collaborative services are organised, the question of accountabilities becomes a testing issue. For some, it may be quite disconcerting to think that they may be supervised, managed or evaluated by someone who does not share their background or training. The underlying concern may be framed in terms of the question: 'who will take the blame if this goes wrong?'. Equally, though, practitioners may feel uncomfortable with the idea that their own performance may be judged by someone who does not really appreciate what their role involves in terms of skills and expert knowledge. It may seem inappropriate that career prospects could be affected by such 'uninformed' opinions.

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- **Disputed decision-making powers.** In the same vein, the issue of the legitimacy of judgements about one's professional performance are paralleled by concerns about who has the ultimate authority to make operational or strategic decisions. At what point does collective team responsibility have to be ceded in favour of the 'lead' organisation for a particular service function? This seems to have been a recurrent issue in areas of practice characterised by the risk of harm, or a sense of urgency, such as child protection, for instance. The decision over whether criminal inquiries by the police should supersede collective action to protect children from harm may impose considerable strains on underlying safeguarding arrangements. The issue raised here is whether collaborative practice is only sustainable in 'fair weather', and when things get difficult agencies revert to more individualised ways of working based on their unique priorities and operational rules.
- **Imported inequalities (of gender, ethnicity or culture, for example).** It is also important to not just concentrate on what might be seen as essentially *internal* tensions facing the collaborative practice agenda. There are likely to be other externally defined inequalities and imbalances at play, represented, for example, by established categories such as gender, ethnicity and culture. External social divisions may be imported into the interprofessional arena, and played out once again in terms which intensify differences of practice, orientation and values. It is well known, of course, that professional hierarchies tend to replicate gender divisions, with those at the 'top' of the tree being more likely to be male dominated. As the world of health and welfare changes are increasingly rapidly, we may also see similar divides emerging on grounds of culture and ethnicity. It is, of course, crucially important that implicit professional hierarchies do not become another vehicle through which forms of social inequality and oppression are made manifest.

TOWARDS EFFECTIVE PARTNERSHIPS: CHALLENGES AND OPPORTUNITIES

Given that there are likely to be both positive attractions and inbuilt tensions in the project of establishing effective partnerships, it will help here to set out some of the ways in which challenges and opportunities may be approached in undertaking this task. First, it is clear that there are a number of endemic obstacles to better levels of cooperation, although each of them may be seen to represent an underlying test of commitment, running from the strategic and structural levels all the way through to the individual practitioner. Thus, for example, there is a fundamental question as to the level of resources which it is thought appropriate to invest, and what represents a comparable level of input, given that agencies have very different capabilities in terms of what is available to them. In fairly simplistic terms, of course, this may be

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reduced to a question of how much each partner is willing to invest; however, it is not just a question of making a cash contribution, especially given that some will find this easier than others. Also involved in this kind of calculation is the extent to which parent agencies will make key personnel available, and on what basis. Other contributions 'in kind' may be important; a commitment to share information, as far as legally permissible, may be seen as a significant symbolic contribution, too.

Of equal significance in symbolic terms is the readiness of agencies to demonstrate their support, by taking an active role in collective management, perhaps, or by showing a common readiness to respond to external pressure or adverse publicity. In my own past experience of interagency practice, I can recall how important it was to feel that senior managers were involving themselves in the project, simply by attending management committee meetings. It became distinctly awkward for those practitioners whose managers never seemed to be able to attend; this implied an underlying lack of interest, of course.

As well as the substantive and symbolic value of resource commitments of various kinds, it is important to develop a common sense of purpose and working practices, especially where the initiative in question is breaking new ground. It is at this point that the issue of 'multi' versus 'interagency' working emerges with some impetus.

As one commentator observes, in the 'health literature the terms "multiprofessional" and "interprofessional" are often used interchangeably'. This can give rise to considerable confusion, and we are reminded that this is an important distinction to make, representing the difference between, say, working alongside one another in a common location, but on separate tasks; and, on the other hand, working on a commonly agreed and integrated activity which necessitates a level of shared understanding and mutual investment. This is much more clearly an interactive process than simply working in ways which are complementary, but do not involve any significant degree of collaborative engagement. It is suggested, for example, that fully interprofessional working requires participants to be effectively prepared for this in a number of ways. They must "know about" the roles of other professional groups'; they must 'be able to "work with" other professionals in the context of a team'; and they should be ready to "substitute for" roles traditionally played by other professionals' when this would improve processes and outcomes for service users. This suggests, in turn, that we cannot expect genuinely interprofessional practice to 'just happen': it must be prepared for, both strategically and also at the level of practice. Participants should be entitled to expect that they will be offered

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joint training and preparatory activities such as team building, for example, but they must also be prepared to engage in joint working with open minds. In this spirit, a crucial question for those getting involved in collaborative practice is: 'what are you prepared to give up?' This is a question for agencies as much as it is for practitioners, of course, but it is of major significance if working together is to move beyond a token aspiration. Thus, for example, agencies may have to be prepared to give up decision-making powers, in certain respects, as when the police agreed to negotiate over whether or not to prosecute in the juvenile diversion project in which I was involved. Equally, though, it may be important for medical practitioners to reconsider the way in which they view the diagnostic process in some contexts. Not only does this sort of adaptation contribute significantly in equalising implicit power imbalances between disciplines, it also importantly underpins approaches which seek to engage service users more actively as partners and as key decision makers in their own right. The question of 'giving up' some aspect of one's professional authority or operational autonomy should not be underestimated, though. We know, for instance, that the question of who is authorised to take certain statutory measures in mental health is a matter which has tested the strength of collaborative relationships in the recent past, and there are always likely to be problems if certain participants feel that they are being required to give up hard won status and authority under duress. Similarly, the emergence of new roles in the interests of better collaboration can also have a disruptive effect, as with the introduction of 'primary care mental health workers'.

Despite the evident challenges to be met, an equivalent range of opportunities present themselves, which can be summarised briefly here. The exercise of developing collaborative activities is, in itself, likely to provide a source of mutual support. Where practitioners may be seeking to develop new and creative services, the availability of mutual support from across professional divides may be of significant value. This, in turn, may well help to underwrite a sense of cohesion and common purpose, organised around the sense of shared goals which are represented in terms that transcend relatively narrow professional interests. Similarly, the availability of external sources of support may well enable developments to establish and maintain a degree of credibility amongst colleagues and in wider domains, even where they appear to be working 'against the grain'. Finally, and most importantly, the implementation of this kind of strategy offers the possibility of added value; that is, it can legitimately aspire to offer more than the sum of its parts, and to deliver a form of intervention which treats the service user as an integral whole, rather than a collection of atomised and unconnected 'problems'.

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Given these alternative perspectives, it is perhaps unsurprising that the idea of interprofessional working generates some quite polarised views about its value and potential. In reality, of course, it is equally capable of achieving positive benefits, and leading to problematic outcomes and conflict. What is necessary, though, is to have a common view of aims and purposes, and to develop appropriate strategies and problem-solving approaches to enable these to be realised.

STRATEGIES AND APPROACHES: MAKING COLLABORATION WORK

It will be helpful to outline at this point some of the probable ingredients necessary for effective collaboration, as well as thinking about some of the ways of combining these.

First, it may be useful to begin by acknowledging that working in partnership across agency or disciplinary boundaries is a special form of teamworking. In other words, many of the same principles apply, such as the need to recognise both the formal roles assigned to members and the roles that derive from their individual qualities and character. In a sense, then, 'normal' teamwork considerations will apply, but will need adapting somewhat to account for professional differences, not just of role, but also of status, expertise and social context. When I first began teaching interprofessional groups of students, I did not take sufficient account of the need first to establish a team ethos and identity before focusing on the inevitable issues of negotiating the formal boundaries of agencies and disciplines. Just as in a learning environment, it may be useful to undertake introductory exercises when establishing an interprofessional team, such as setting mutually agreed ground rules. This task will almost certainly help to clarify the specific challenges arising from complex patterns of obligation and accountability. Where, for instance, do we need to set the limits to openness and sharing of information, in light of agency confidentiality policies? It is, indeed, in the nature of partnership working that the roles adopted by participants will incorporate ambiguities and tensions. Questions of loyalty and belongingness naturally arise, and it is perhaps unsurprising if it appears that for some, their commitment to collaboration is tentative and provisional. They may be unwilling to make a fuller commitment for fear that they will be marginalised by their parent discipline in direct proportion to their level of investment in an interagency enterprise, especially if this is something that is not fully understood, endorsed or valued by erstwhile colleagues. Such tensions are not easily resolved, and are likely to be experienced by most of those involved in partnership working. The accusation of 'going over to the other side' may be difficult to take, and it may also be associated with fears about damaging one's career prospects, too. Retaining

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explicit and consistent links with parent agencies may be necessary, then; this is not, ironically, because of a lack of commitment to joint working, but because sustaining good relationships back 'at home' may actually enhance the ability to play a full part. So managing multiple account abilities and allegiances is a necessary part of the groundwork for good interprofessional practice. A further aspect of this ambiguous position which may be advantageous is the opportunity to act as a mediator between different interests, and to bring opposing viewpoints into discussion, if not agreement. The interprofessional practitioner represents the joint project within his or her own agency as well as the reverse. As a probation officer, I found it particularly helpful, for instance, to be able to call on my teacher colleague's assistance when seeking to negotiate an arrangement to maintain a student in school. Her credibility with other educationalists was naturally much greater than mine.

This, in turn, highlights another sense in which the recognised attributes of good teamworking also apply to collaborative practice. Respect for one another as individuals must be paralleled by respect for each other's professional identities and practices. This is highlighted by long-standing tensions such as the apparent hostility between proponents of social and medical models of disability. Where different practice strengths are to be combined, it seems inappropriate and probably impractical to hold on to extreme variants of such positions. Rather, the starting point must be one of recognition and exchange, building up a mutual picture of the reasons that underlie different priorities and working practices.

It is important, too, to build on this recognition and appreciation of different skills and responsibilities to develop an approach which is complementary. Joint working is not about everybody doing everything, just as preparing for it does not mean learning how to do each others' jobs. Instead, the important skills to develop are the ability to recognise when each other's contribution is appropriate, and to hand over work as and when it makes professional sense to do so. Underlying this, in personal terms, it is also necessary to build up mutual trust and confidence in the other's abilities.

None of this is to suggest that there is no room for disagreement or honest expression of differences of opinion. There are bound to be foggy areas of practice where it is unclear as to who should take responsibility; again, here, the important principle to acknowledge is that constructive criticism is helpful, so long as it does not amount to a devaluing of another practitioner's sense of professional competence. It may not always be necessary, but formal mechanisms can be utilised for the expression and resolution of disagreements in order to acknowledge that it is

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legitimate to disagree, but that working together also necessitates a commitment to trying to resolve differences.

Effective collaboration, then, requires a shared sense of purpose, tempered by a recognition of individual skills and responsibilities, and supported by working arrangements and mechanisms which enable differences to be resolved relatively straightforwardly. Mutual respect is important, too, and this incorporates both personal and professional dimensions.

As we have seen previously, these principles have wider resonances in a social context where professional hierarchies may tend to reflect broader inequalities. Ultimately, it is argued

Effective interprofessional collaboration appears to require practitioners to learn, negotiate and apply understanding of what is common to the professions involved; their distinctive contributions, what is complementary between them; what may be in conflict; and how to work together.

Whether collaborations take place through established teams with a specific remit, or ad hoc arrangements to meet needs in a particular case, they require similar processes of negotiation, preparation and trust building, in order to facilitate effective interventions on behalf of people who use services. These may be difficult to sustain in light of organisational demands and competing pressures, but the centrality of the service user helps to underpin common commitments and focuses practice accordingly; if this is the starting point, then it becomes easier to sustain joint working, even in the face of tensions and interdisciplinary strains.

Exercise 3.2

Do you hold stereotyped views of any other professional groupings within social care or health? Do you think these stereotypes have any basis in fact? Is it better to share them with colleagues or to suppress such beliefs in the interests of good working relationships?

LOOKING AHEAD: PITFALLS AND POSSIBILITIES REVISITED

There are, as we have seen, a number of contemporary developments which seem to point towards increasing expectations that partnership working will become the norm. However, these trends are likely to incorporate both possibilities and

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threats, as we have also acknowledged. In particular, these issues cohere around the challenge of finding a balance between investing considerable time and energy in the necessary working arrangements, on the one hand, and the potential for more effective user-centred services on the other. It is important to recognise, for instance, that a number of commentators have been quite sceptical about the value of collaboration for its own sake, questioning whether there is sufficient evidence available of its potential to justify the apparent levels of enthusiasm which it generates. Some concern has been expressed, for example, that interprofessional working has become 'a new orthodoxy', with untested assumptions informing this, to the effect that it is bound to lead to more efficient and effective practice, almost by definition. This may not be the case, though, if it leads to a diminution in professional standards, or the establishment of monolithic coalitions which turn their faces against service users. Thus, for instance, a collectively agreed decision to intervene in a family against parents' wishes may be harder to challenge where there are no alternative viewpoints being expressed. Clearly, this is not necessarily wrong, but the possibilities of 'groupthink' and unwillingness to acknowledge alternative viewpoints should be recognised:

Collaborative projects tend to reflect the aims and priorities of the key stakeholders only if those stakeholders are involved from the planning stage onwards. This means that while such projects often address the needs of the professionals involved they do not necessarily meet the needs of users and carers.)

It has also been observed that joint working may lead to an improvement in the processes of assessment and decision making, there is 'no evidence' that these in turn lead to better outcomes for service users. A number of other studies have been unable to generate substantial evidence of the benefits of interprofessional practice, and so we must be wary of idealising the notion that working together is always going to lead to improvements.

On the other hand, there is some evidence of improved services and outcomes, especially in the area of work with children and families. Frost et al. have carried out a fairly extensive review of multi-agency teams to support children and families. In particular, good working relationships can be seen to offer the opportunity to utilise different perspectives productively: 'Joined-up working does not necessarily mean doing away with difference'. Indeed, it seems to be beneficial to actively seek out the alternative options that this may provide.

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In areas of practice such as early years' services, joint working is fairly well established, and is more or less accepted as the norm. Early years' services, for instance, have an established tradition of collaborative working, where centres are established within communities to 'bring resources together and provide a range of non-stigmatising service provision for families'. In this context, it is suggested that bringing together generalist and specialist professional interests offers a number of potential benefits, including more needs-responsive and less stigmatising services. This was one of the underlying aims of Sure Start, where the aim of providing accessible 'joined-up' services to marginalised communities was at the heart of the initiative. It must be acknowledged, though, that subsequent evidence has been equivocal as to the real achievements of Sure Start overall. In addition, disentangling the impact of multi-professional working from the direct effects of additional expenditure, or the benefits of providing more local services, is a difficult task. Nonetheless, successful examples of this kind of model are identifiable, featuring jointly agreed 'meta-strategies', recognition and respect for 'differences', effective 'dissemination' of common aims and objectives and a willingness to learn from each other, at both practitioner and agency level.

We should perhaps be somewhat cautious about overstating the benefits directly attributable to the breaking down of agency and professional divides. On the other hand, we can begin to identify some common features of 'successful' multi-agency working, and what approaches might help to underpin this. The starting point must be a genuine and active commitment from participating agencies. This provides the basis of support which practitioners will require in order to feel comfortable about sharing ideas, taking professional risks and sometimes admitting uncertainty and asking for help.

Sometimes, too, it is a matter of making sure that practical challenges do not intrude, or create divisions. Where interprofessional teams are established, there are very often issues of parity of status, pay and conditions and authority, which can lead to persistent feelings of unfairness and unequal treatment. Thus, the groundwork is important, both at agency level and at practitioner level.

Practitioners themselves have to become familiar with different ways of working, different systems and multiple lines of accountability. While there is much rhetorical encouragement to work across conventional boundaries at present, this still necessitates some detailed adjustment in the mindset of those directly involved in new ways of working. Stereotyped views must be kept in check and taboos

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challenged; I remember being told forcefully and somewhat indignantly by a medical student at an interprofessional learning event: 'we're not all slaves to the "medical model", you know'.

Beyond this, a degree of openness and acceptance of challenge is required, which is sometimes arguably absent from the uni-professional environment, and so becomes even more difficult to activate in a multiagency setting. By the same token, though, exchanges of this kind can only be productive if they are grounded in a spirit of respect and recognition of professional difference, and the value of other points of view. These considerations suggest that it is not just a question of attitudes and values, but that these must be demonstrated in action, through particular styles of working, which cannot be routinised or individualistic, but necessitate sharing, reflection, debate and then a mutual acceptance of responsibility for the outcomes of practice. This requires a substantial degree of mutual trust and respect, of course, and there are many reasons that this may be difficult to achieve in the real world of collaborative practice; there must, however, be underlying goals if such ways of working are to have any hope of being consistently effective.

CONCLUSION

The aim of this chapter has been to set out some of the key benefits and obstacles to collaborative working. In essence, it is clear that there is considerable support for the idea of joint working both in terms of government and agency policy, and in terms of professional, service user and practitioner aspirations. However, historical differences in the ways in which professions have developed have often acted as an impediment to collaboration.

We have also observed that **working together** may **lead to improved services, although this is not a given**. Precisely because of this, **effective joint working needs to be 'worked at'** consistently and continually.



CHAPTER

4

WHAT IS A GROUP? AND WHAT DOES IT DO?



GROUPS

a guide to
small group work in

healthcare,
management, education
and research

Glyn Elwyn
Trisha Greenhalgh
and Fraser Macfarlane
Illustrated by Siân Koppel

 CRC Press
Taylor & Francis Group

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Groups: A Guide to Small Group Work in Healthcare

By Glyn Elwyn, Trisha Greenhalgh, Fraser Macfarlane

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WHAT IS A GROUP? AND WHAT DOES IT DO?

Glyn Elwyn, Trisha Greenhalgh, Fraser Macfarlane

Excerpted from *Groups: A Guide to Small Group Work in Healthcare*

None of us are as smart as all of us.
Japanese proverb

WHAT IS A GROUP?

There are many definitions available, and there has been considerable debate about their merits. MLJ Abercrombie, whose research into the use of small groups in higher education broke new ground in the 1960s, defined a group as *'a number of people who are in face-to-face contact, so that each of them can interact with all the others'*.

Another early seminal writer on groups, Wilfred Bion, distinguished work groups from family, friendship or therapeutic groups. He defined a work group as *'a planned endeavour to develop in a group the forces that lead to a smoothly running co-operative activity'*.

John Hunt, writing a decade later about group work in management, defined a group as *'any number of people who are able to interact with each other, are psychologically aware of each other, and who perceive and are perceived as being members of a team'*.

Levine and Moreland define a group as several people *'who interact on a regular basis, have affective ties with one another, share a common frame of reference, and are behaviourally interdependent'*.

Whatever the finer points of the definition, it is generally agreed (or at least assumed) that the members of a group have a common purpose or task, and that the interaction between them is closer, and follows a different pattern, than in casual or brief encounters. There is no fixed definition of how many members count as a group, but the dynamics of interaction change considerably if the group has more than about ten members. In practice, groups usually have between three and eight members.

The difference between a group and a team is inconsistently defined. Although Hunt and others use the terms 'group' and 'team' interchangeably, much of the recent research in social psychology has demonstrated that although teams are definitely a form of group, not all groups can be regarded as teams. For the purposes of this book, we have defined a group as a small number of people who have:

- a shared identity
- a shared frame of reference and
- shared objectives.

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Excerpted from *Groups: A Guide to Small Group Work in Healthcare*

We have defined a team as a group in which the members distribute functions (i.e. in which there is an explicit division of labour).

Groups can be broadly classified into the following categories.

- *Formal groups* are created as mechanisms within a wider organisation and supported by the structures and power relationships within that structure. Their functions tend to be clearly specified, their membership restricted and their control over resources limited. Formal groups include project teams and (sometimes but not always) committees, boards of directors and boards of examiners.
- *Informal groups* are looser and more erratic in their behaviour and less constrained by rules and expectations. They are usually based on friendship and/or prior shared beliefs about how things should be done. It is often in informal groups that new ideas are tested and creative solutions explored. Moreover, it is often within these informal groups and networks that real power resides within organisations, and the importance of this fact is widely recognised in the literature on social network theory.

When writing this book we were conscious that the very notion of a collection of individuals with an identity and sense of common purpose is a rare and special concept. Most so-called 'groups' would not fulfil even the most basic of the above definitions. How often, when you have been asked to lead or facilitate a group, have you been billeted into a reluctant, time-limited and somewhat confused gathering in which the members do not know (or even desire to know) each other's names, and have no shared perspective or mutual trust. Whilst we recognise that this is a common experience, this book is not about what to do when there is inadequate time or commitment to get the basics right. However, although we recoil from addressing this worst-case scenario, we also recognise that even with considerable commitment from the facilitator and the members, practical constraints often require compromise. The counsel of perfection suggested in some of the later chapters of this book may need to be modified in response to both external and internal reality!

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Glyn Elwyn, Trisha Greenhalgh, Fraser Macfarlane

Excerpted from *Groups: A Guide to Small Group Work in Healthcare*

Most groups are a motley crew.



WHAT DOES A GROUP DO?

The *content* of group work (i.e. what the group does) varies enormously, and it obviously depends on whether the group is formal or informal, the reason why it was set up, and the task or tasks that it sets out to address.

In contrast, the *process* of group work (i.e. how the group does it) tends to follow a common pattern whatever the group has been set up to achieve. The defining features of the group process are as follows:

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1. *Active participation* – i.e. everyone in the group takes part in some way. Note, however, that some participants naturally have a more interactive style than others. A member may contribute actively to the group process by body language, facial expression and the sensitive use of silence, as well as by verbal expression.
2. *A specific task* – i.e. a defined and focused set of objectives. All group members must understand and agree on the objectives at the outset of the task, otherwise the group quickly becomes dysfunctional and frustrated.
3. *Reflection* – i.e. the group members incorporate experience into their shared task through an explicit process of discussion, questioning, evaluation and self-reflection.

Table 4.1 • Examples of different types of group (adapted from a number of sources)

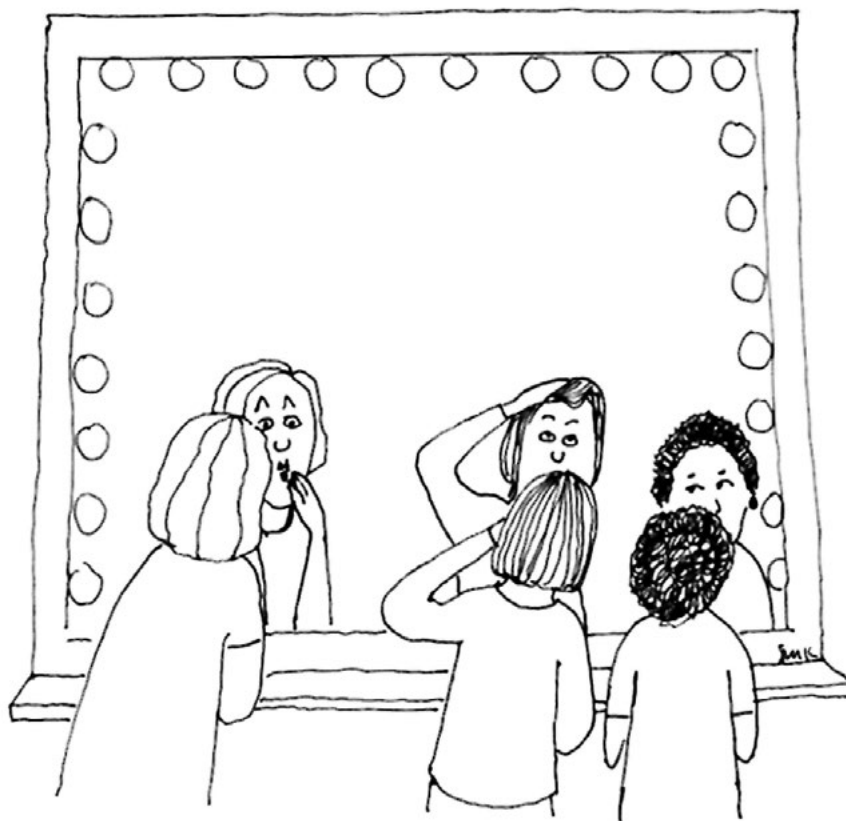
Type of group	Description	Recommended use
Problem-oriented learning group (see p. 96, Figure 4.1)	Participants work in small groups (typically five or six members) and address complex problems chosen in advance by the tutor. They may explore any aspect of the problem that they feel is relevant. The tutor (or tutors) act as a resource for expert information as well as having a facilitator role	Arguably, this promotes deep learning through discussion and reflection. Improves motivation and encourages independent reading, literature searching and research. Is said to encourage problem-solving skills, but evidence for this is controversial
Project group	The group works on a joint task in four phases, namely scoping, designing, producing and presenting. The group must share ideas, identify and use individual members' skills, and take group responsibility for the range and direction of work covered. The tutor plays a supportive role	Allows in-depth study with freedom to explore different aspects of the topic and different learning methods. Requires participants to take responsibility for tutorless group work
Seminar group	Group discussion with fairly academic aims. Participants present material on a topic set by the tutor, followed by discussion and feedback. Generally, all participants prepare the material, and the tutor selects one or more of them to make a formal presentation	Promotes skills in literature searching, critical appraisal, presentation and critical discussion
Syndicate group	Participants work in tutorless groups on a structured assignment set by the tutor. The assignment generally includes a detailed set of questions or tasks with references from set books and journals. Different syndicate groups may work on different aspects of a larger problem and share their findings in a plenary session. The tutor may summarise the findings in a final lecture	Allows the tutor to exercise control over content while giving participants freedom to work without direct supervision and in their own way
Tutorial group	Participants discuss material that has been previously taught or assigned (e.g. in a lecture). They must prepare for the session and note down issues that they wish to discuss. Tutor should focus entirely on work prepared (and questions asked) by the participants	Allows participants to clarify and expand on topic material. Allows the tutor to check their level of understanding

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Excerpted from *Groups: A Guide to Small Group Work in Healthcare*

Reflection is a crucial feature of deep learning.



WHY IS GROUP WORK SUDDENLY SO POPULAR?

Organisations of all sizes and shapes are recognising that the achievement of successful outcomes, whatever those outcomes might be, is dependent on three critical lessons learnt over some 50 years of trial and error in various fields of research and practice:

- process (how something is done) affects the outcome (the results or the product)
- in general terms teams are more successful than individuals
- group member participation leads to greater commitment and success.

These principles guide a whole spectrum of activity from management (total quality management, continuous quality improvement), to education (problem based learning, learning sets) and research methods (action research, exploration of

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perceptions and consensus testing). The generation of greater involvement and participation within organisations leads to an increasing use of groups and teams of all types and sizes. The tasks with which these groups or teams are charged may vary immensely – to change the ways in which ‘things are done around here’, to solve problems, to make decisions, to coordinate complex processes, to learn new skills – but all of them will face similar challenges of interpersonal communication.

The rise in popularity of group work in educational settings is part of the ‘liberation’ approach to learning and change, which is based on the premise that learning is best done *by reflecting, discussing and doing*, rather than *by receiving*. This approach also proposes that the subject matter should be of direct relevance, that participation is a necessity and that the whole person needs to be involved – their feelings as well as their intellect – so that the learning is pervasive and lasting.

This contrasts starkly with the instructivist method of learning which many of us remember from our school and undergraduate days, in which teachers typically present an external reality (a body of knowledge) which is independent of the student and which he or she is expected to assimilate. The instructivist school does not see any need to consider the impact of learning on the person and how they might integrate new understandings into their own personal contexts. Educationists are increasingly using groups to *ensure* that individuals participate actively in the learning and problem-solving tasks.

TECHNIQUES FOR GROUP WORK

The different techniques commonly adopted for group work are summarised in **Table 4.2**. Note, however, that this list is neither static nor exhaustive, and that many other types of group, and uses for the techniques shown, can undoubtedly be found.

Jacques describes three broad categories of group techniques:

- techniques concerned with *cognitive objectives* (knowledge, problem solving, analysis, evaluation)
- techniques concerned with *creative objectives* (producing imaginative solutions, linking the emotional and the intellectual, seeing new relationships)
- techniques concerned with *social objectives* (developing individual or group awareness, developing communication skills, breaking down interpersonal barriers).

All of these techniques are covered in more detail in the chapters that follow.

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Table 4.2: Examples of techniques used in group work (adapted from a number of sources)

Method	Description	Recommended use
Brainstorming	Should follow a three-step sequence: first, identify ideas through free discussion and record so all are visible [e.g. 'Post-it' notes, flip chart]; secondly, clarify and categorise ideas; thirdly, evaluate ideas and summarise. The tutor should ensure that all ideas (however 'crazy') are welcomed and considered. The first step should continue until no new ideas are generated	Promotes initiative and lateral thinking. Good for situations in which creative solutions are required. May form the initial stage of a problem-based learning cycle
Buzz grouping	Used in large group situations (e.g. lectures) in which an element of small group discussion is desired. Participants are asked to turn to their neighbour and discuss a topic briefly. Pairs can then be merged to form fours or sixes. The lecturer may ask for a show of hands in response to questions such as 'How many groups had someone who didn't follow the question?'	Can dramatically relieve boredom and refocus attention in a lecture. Enables the lecturer to obtain an honest estimate of misunderstandings, as the group, rather than the individual, owns the response
Controlled discussion	The tutor leads and directs discussion on a predefined topic. Participants either ask the tutor questions or (more commonly) the tutor directs questions at participants in the style of 'Socratic dialogue'	Useful for checking knowledge and understanding of presented material. Can be used with large groups, but can inhibit open discussion. If overused it may be unpopular with participants
Free discussion	Material such as a case study is circulated either in advance or at the start of the session. The tutor invites and facilitates discussion, which should range freely around the topic area. There need be no clear resolution	Encourages interaction and exploration of values and feelings. Good for controversial or sensitive material
Games and simulations	The tutor introduces a game (i.e. an artificial and typically competitive situation) or a simulation (i.e. a mock-up of a work situation), explains the rules, and allocates a time period. The tutor may take part in or facilitate the exercise. The game or simulation is followed by a debriefing to clarify what has been achieved	Promotes experiential understanding and allows participants to develop skills that can be transferred to the work environment
Role play	The participants enact a scenario, taking on various predefined roles. The tutor should first explain the background to the session and assign roles (usually as a short written brief). He or she may also take on a role. Participants then enact the scenario, which may be videotaped. Not all group members need play a role – indeed, it is better for some of them to observe. Debriefing, in which participants describe what they felt while playing the role, is essential for affective objectives. Participants must formally de-role before the end of the session, especially if their role was emotionally charged (e.g. that of a bereaved person)	Allows the participants to explore the feelings and perceptions of individuals in different life situations. Good for promoting communication skills
Snowballing	The participants discuss a topic in pairs, the pairs then join to make fours, then eights, and so on. At each stage, the groups define the range of views and identify contentious aspects of the problem. Usually the tutor supplies written stimulus material (e.g. a case study) at the outset	Promotes the exchange of ideas and values, and allows participants to clarify their own views. Good for discussion of controversial or sensitive material

GROUP DEVELOPMENT

In 1965, Tuckman published a seminal paper in the *Psychological Bulletin*, which argued that all groups tend to develop through four main stages, namely forming, norming, storming and performing. Although Tuckman's phases are still probably the most commonly used classification for group development (and the one we shall use in this book), other taxonomies are popular in some circles. For example, Schein's four-phase sequence of dependency, conflict, cohesion and interdependence

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(corresponding to forming, storming, norming and conforming) is more commonly used in management. As Hunt warns, these different phases should not be seen as a model to be followed, but rather as an analysis of what tends to happen.

WHY DO PEOPLE JOIN GROUPS?

Schein has suggested that people join groups for one of three reasons:

- to achieve shared objectives (i.e. those mutually agreed by the members)
- to achieve personal objectives (i.e. those not explicitly agreed by other members)
- 'to work in a group' (i.e. to address a social need through the group process).

There is a school of thought that places unconscious motives high on the list of individuals' reasons for forming and joining groups. Bion, who is credited with being the founder of the influential group relations theory used by therapists at London's Tavistock Clinic, stated that 'the human individual is a political animal who cannot find fulfilment outside a group and cannot satisfy any emotional drive without expression of its social component'. He argued that for the individual, the task of establishing emotional contact with the group is a primitive and formidable act that involves both regression and loss of 'individual distinctiveness'. Indeed, Freud defined a group as 'an aggregation of individuals all in the same state of regression'. His theory was that large groups such as armies or churches become integrated social systems as each individual identifies (through transference) with the leader or figurehead.

Whether you are an opponent or a strong supporter of the psychoanalytical approach to relationships in groups (and between groups and the external world), you will no doubt acknowledge the powerful social and emotional dimensions of the group experience. What people *feel* when they are in a group can be as important as what they *say*, the skilled facilitator is able to recognise, contain and channel the emotions of the members to help them to achieve shared objectives.

WHAT GOES ON IN GROUPS?

Schein described three types of behaviour that occur in groups:

- 1 *Task behaviour* is oriented to attempting to achieve the group's defined task. It includes:
 - stating goals, defining problems, proposing how to proceed

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- seeking and exchanging opinions or information
 - combining, improving and building on these initial suggestions
 - seeking or taking decisions.
- 2 *Group behaviour* is oriented to helping the group to survive and grow. It includes:
- establishing trust and mutual support
 - encouraging appropriate contributions from all members
 - resolving differences between members
 - setting and enforcing standards of behaviour (e.g. about timekeeping, interrupting, and so on).
- 3 *Individual behaviour* is oriented to the needs and interests of the individual, and may interfere with the group process. It includes:
- blocking (attempting to arrest or divert the group in order to address a personal agenda)
 - dominating other members
 - displaying verbal or physical aggression
 - withdrawing from the group
 - seeking help or recognition (e.g. through self-deprecation or emotional outbursts)
 - forming pairs or cliques
 - grumbling or 'badmouthing' members outside the group.

LEADING AND FACILITATING GROUPS

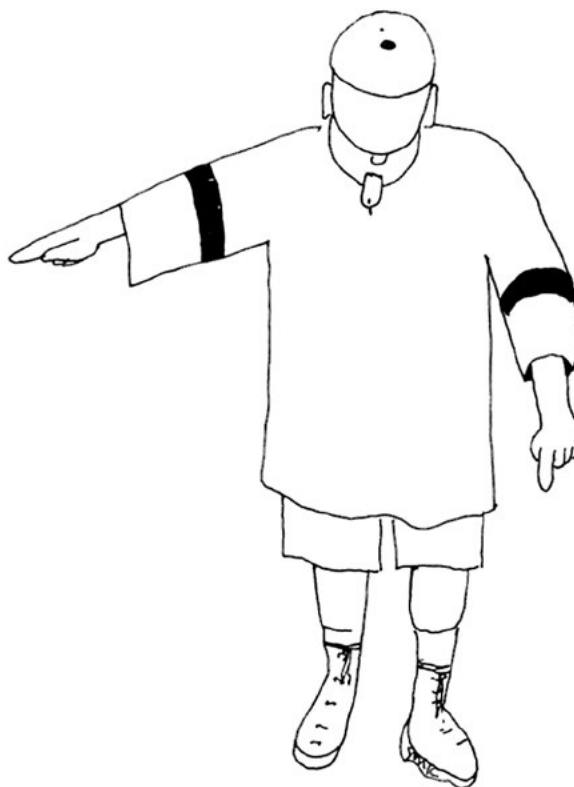
Leading and facilitating are very different skills, and they may be incompatible. The conventional leader of a group (e.g. teacher, tutor, coach, manager, director or 'boss') generally has a strong vested interest in obtaining a particular outcome from the group, and may be unable to tolerate dissent from his or her preferred course of action. A facilitator, on the other hand, may be deliberately chosen because he or she does *not* have a vested interest in the outcome of the group work, or a hierarchical relationship with the group members.

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Ready, steady, go!



Heron has described six categories of intervention in groups, which fall into two main groups, namely authoritative (directing, informing and confronting) and facilitative (releasing tension, eliciting and supporting). Jacques divides the purpose of facilitation into the following roles.

- 1 *The task role* involves ensuring that the group completes its task, for example by:
 - focusing members on a particular topic
 - suggesting ideas for the content of discussion
 - clarifying and elaborating the contributions of group members
 - challenging ideas and hypotheses
 - seeking or giving information

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- summarising work done so far
 - questioning the direction and depth of discussion.
- 2 *The group role* involves establishing and maintaining effective functioning of the group, for example by:
- promoting a climate that is open, supportive and trusting
 - gatekeeping (i.e. ensuring that members who have a contribution to make are given the opportunity to do this)
 - managing conflict
 - relieving tension (e.g. through humour)
 - setting standards – encouraging members to establish and follow ground rules
 - identifying and managing individual behaviours (see above) that may interfere with the group process.

As you will see from the examples given throughout this book, there is no single 'best method' for facilitating a group, or optimum balance between the more and less directive facilitation styles. The many terms used to depict leaders and facilitators (tutor, trainer, coach, teacher, facilitator, chairperson, mentor, reviewer, and so on) will give you an inkling of the subtle variation between the different roles depicted by the titles.

In addition to the two roles described above, the facilitator of an educational group (e.g. a university tutorial) must usually strive to ensure that the learners become increasingly self-reliant, independent and confident in their studies. Groups outside the formal educational setting (e.g. learning sets) may share similar aims for the personal development of their individual members. Developing communication skills and breaking down interpersonal barriers may also be explicit aims of the group. Thus the role of the facilitator may evolve from being more authoritative to more facilitative throughout the lifetime of the group. Rather than aspiring to a single style of facilitation, we recommend that potential facilitators should aim to become comfortable with a range of styles.

WHAT DOES THE IDEAL GROUP LOOK LIKE?

John Hunt has suggested that, for successful group work, a number of features are required.

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- 1 The members:
 - work cooperatively, not competitively
 - 'get along' with one another
 - take incentives and rewards collectively, not individually
 - are aware of the nature of the group process and the stages of group development.
- 2 The group:
 - has approximately five or six members
 - has autonomy to address its task
 - has an effective leader or facilitator
 - is adequately resourced in terms of time and administrative support
 - operates in the context of a supportive organisation or community.
- 3 The task:
 - involves all members, draws on the skills of different individuals, and requires coordination
 - is concrete rather than abstract
 - has a precise statement of objectives, a definite beginning and end, and measurable indicators of success.

Box 4.1 lists the determinants of group effectiveness and **Box 4.2** lists the tasks and processes for which group work is particularly suited.

DOES SIZE MATTER?

Observational studies of naturally occurring groups with high levels of interaction between members have demonstrated that these groups normally contain two or three individuals, and rarely include more than five or six. One explanation that has been suggested is that people become confused by groups that are larger than six members, since the number of potential relationships rises sharply as each new member joins.

The number of people that any one individual can observe, communicate actively with and be involved with is around seven to eight. It is no accident that this is the typical maximum number of people usually invited to share a communal meal with

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the hope of maintaining one conversation at any given time. It is impossible to control large groups for any significant period of time, and members tend to feel (correctly) that their individual influence over the group process diminishes rapidly above the threshold of five to six people.

BOX 4.1: THE DETERMINANTS OF GROUP EFFECTIVENESS

The individual members

- Personal objectives
- Understanding of the task
- Understanding of the group process

The group

- Size
- Stage of development
- Appropriate mix of knowledge and skills
- Quality of facilitation

The task (see p. 29)

- Nature
- Salience
- Clarity
- Criteria for successful achievement

The context

- Physical environment
- Time and resources allocated
- External (organisational) factors

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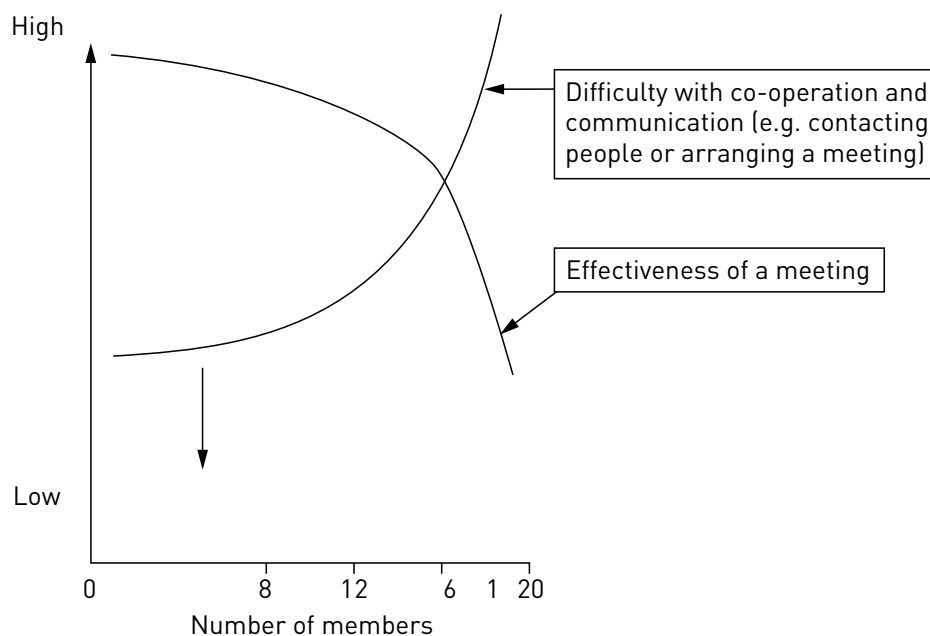
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BOX 4.2: TYPES OF ACTIVITY FOR WHICH GROUP WORK IS PARTICULARLY SUITED

- Completing a complex task that requires input from multiple members (e.g. planning an induction and training programme for new employees)
- Solving problems
- Developing communication skills
- Developing and applying new ideas
- Changing attitudes of individual members
- Developing transferable skills for continuing professional education (e.g. project planning, time management, identification of one's own strengths and weakness, assumption of responsibility for learning)
- Developing transferable skills for the workplace (e.g. leadership, prioritising, mutual support)

Figure 4.1 • Co-operation becomes difficult with too many members



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Øvretveit described the increasing difficulty of achieving cooperation between groups of people as their number increases (see **Figure 4.1**). Small group work starts to become confused when the threshold of eight or more participants is exceeded, and the task of coordinating a larger project team, convening a meeting or even maintaining informal contact becomes very difficult if numbers approach 15 or more members.

Some situations do allow groups to grow larger, and are usually characterised by contexts that do not require close interaction between members. In these situations the concept of group *niches* has been described. The 'niche' is the boundary that can be drawn around the group, the amount of time available for meetings, the space allocated, the resources and 'rules' about membership. If this niche has a high volume, then membership can expand, provided that there are no competing niches with overlapping interests.

As groups increase in size, they will commonly exhibit directive-type leadership, which appears to be both enabled and accepted. Perhaps this is because the group recognises that this is one of the most efficient methods of achieving coordination. Increasing size also leads to declining levels of participation and the development of a controlling nucleus. This can often result in declining participation and commitment, which in work environments can translate into lower levels of performance and eventually to disengagement. However, size is not the only factor that determines performance. The types of members, and whether they are similar or dissimilar.

In summary, small groups that require active communication and interaction between all members should not contain more than eight members, and ideally should have a smaller number.

GROUP WORK IS NOT A PANACEA

Working in groups is becoming so fashionable that some people have started to use it uncritically in educational and research settings, or to address a host of different problems in the workplace. It is important to recognise the limitations as well as the strengths of this form of interaction. **Box 4.3** lists some activities that are less suited to the small group process, and which may cause frustration if offered to a group. The impact of the nature of the task on the group process is discussed further in Chapter 2, and the specific limitations of and cautions about group work are discussed in detail elsewhere throughout this book.

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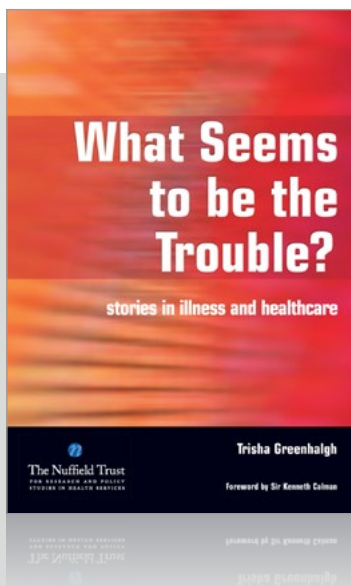
BOX 4.3: TYPES OF ACTIVITY FOR WHICH GROUP WORK IS LESS SUITABLE

- Simple, routine tasks that could be easily achieved by a single individual (e.g. completion of an inventory)
- Expert tasks (i.e. those requiring input largely or exclusively from an individual with unique skills or experience)
- Memorising facts (e.g. for traditional examinations)
- Individual activities (e.g. writing an essay)
- Activities involving professional intimacy (e.g. 'clerking' a patient)

CHAPTER

5

STORIES AND ORGANISATIONS



This chapter is excerpted from
What Seems to be the Trouble?
Stories in Illness and Healthcare

By Trisha Greenhalgh, Merrill Goozner

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STORIES AND ORGANISATIONS

Trisha Greenhalgh, Merrill Goozner

Excerpted from *What Seems to be the Trouble? Stories in Illness and Healthcare*

My family and I always believed that the NHS provided the best treatment in the world. We now know that this is not the case. David, my father, died late last night in your hospital after his long fight against cancer. He was admitted three days ago to be operated on to alleviate his symptoms. He was starved for 24 hours in readiness for the operation. The operation was cancelled on the first day and then again the day after that. You simply cannot starve cancer patients for days on end in the hope that their operation might be carried out. Is this any way to treat a person in the last three days of their life on this earth? I am shocked and amazed that you consider the management of my father's case and the administration of his treatment to be of a good standard.

Comment in a Visitors' Book in a hospital chapel. Reproduced with permission from 'The role of stories and storytelling in organisational change efforts'

Narrative approaches seek to understand organisations, and also drive change, via the stories told within them and the stories told about them. In the previous chapter, I suggested that the story has a number of advantages as a tool for learning. Many of these same characteristics make stories a uniquely useful tool for understanding and attempting to change organisations.

The first of these advantages is that stories embrace complexity and are embedded in other stories. Organisations are complex entities with fuzzy and inconstant boundaries. What we call 'the organisation' means different things to different people, and it changes from day to day and year to year. Large public-sector healthcare organisations are more complex than most, and those in the UK are embedded in the wider National Health Service, itself part of the Welfare State, and linked (to a greater or lesser extent in any locality) with social services, schools, the voluntary sector, and so on. Even something as superficially simple as a GP surgery or a hospital clinic is remarkably difficult to draw out on the back of an envelope – which is why stories about the NHS are often so much more meaningful than the charts and flow diagrams that are supposed to represent its structure and lines of accountability. Events in any story unfold because of the dynamic interplay of the actions of different players, each of whom is variously enabled and constrained by the context(s) in which the action happens. Thus storytelling, although conventionally seen as an untidy, meandering and needlessly discursive means of representing

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reality, may actually be the clearest and most efficient means of capturing the organisational dimension of the illness experience or the provision of healthcare.

One technique that we all use unconsciously to convey and make sense of complexity is what Boje has called 'terse stories'. Stories in organisations rarely come fully formed with a beginning, middle and end linked by a plot. More often, people speak in story fragments – that is, brief accounts that are not in themselves coherent or meaningful, but which make sense when placed in the wider cultural and historical context and mental schemata shared by the organisation's members. For example, the statement 'the boss is late again' told informally in an organisation draws on a shared understanding among the staff of the boss's previous behaviour, the meaning the staff attach to that behaviour, and their assumptions (true or not) about the boss's personality and private life. The essence of a terse story is not what is stated in the fragment but what remains *unstated*, since these are the elements that do not need to be expressed. These unstated elements are the researcher's clues to the shared assumptions and perspectives on reality that make up organisational culture.

The second advantage of stories in an organisational setting, and one which is especially relevant in relation to organisational change, is their sense making potential. To be successfully assimilated by members of the organisation, a proposed change must make sense in a way that relates to previous understanding and experience. People caught up in a change initiative (or who are trying to 'stay afloat' in a changing environment) engage in a continuous stream of experience and action, which generates a succession of equivocal situations. They then *retrospectively impose* a structure or schema to make these situations sensible. In other words, the act of sense making is itself the construction of a narrative, requiring elements to be selected out, highlighted as significant or surprising, juxtaposed with one another and with existing cognitive schemata, and thereby given meaning. The story serves as both an anchor and a springboard in times of rapid change.

'When a decision is at hand, the old stories are recounted and compared to unfolding story lines to keep the organisation from repeating historically bad choices and to invite the repetition of past successes. In a turbulent environment, the organisational halls and offices pulsate with a story life of the here and now that is richer and more vibrant than the firm's environment.'

Some organisational anthropologists have gone so far as to argue that storytelling is essential to adaptation and survival in large, impersonal, bureaucratic and

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technology-dominated institutions. Imagine learning how to be a doctor, nurse, volunteer or chaplain (or indeed to play any other organisational role) in the NHS without the use of stories. I recently organised a work-experience week for a group of 16-year old school pupils at my local hospital. The pupils made very little use of the written guidance I had painstakingly produced on what (not) to wear, where (not) to go and what (not) to do. Of far more use to them were the stories told in tea-breaks by my medical-student helpers of incidents when they had been caught eating crisps on a ward round, inadvertently upended a patient's dinner by sitting on a bed, or turned up to Professor So-and-So's teaching session in a risqué T-shirt. These informal stories conveyed the organisational dos and don'ts far more effectively than my structured lists – and they also humanised and personalised organisational culture in a way that the formal instructions had failed to do.

The third characteristic of stories relevant to organisational studies is that they are memorable. Stories are image-rich, action-packed and full of surprises. Just as the story is the unit of individual memory, the folklore passed on through stories is a key element of institutional memory. 'Learning the ropes' in an organisation often includes picking up stories about people who left years ago but whose actions or experiences have become woven into stories told by present-day staff and clients. Stories about the much-loved previous chief executive, for example, may set the context for a general lament about the weaknesses of the present incumbent of the post.

Fourth, stories can reveal the counterculture of an organisation – in which the seeds of change can very often be seen. Funny stories in particular, shared by low-status staff in informal space when the boss is not around, serve to reveal absurdities, assign alternative identities to key characters, expose red tape, and draw attention to inequities such as oppression or disempowerment of staff or patients. Yiannis Gabriel's fieldwork has highlighted the contrast between organisations' official version of their own story ('well-oiled machine, cutting-edge technology') and the subversive metaphors used by the members ('the [pompous, incompetent] management, nothing works round here').

Subversive stories feed the creative imagination of organisational innovators. They create the backdrop for new visions and embody permission to break the rules. In an old-fashioned machine bureaucracy, behaviours and events that go beyond the existing structures and systems are implicitly (and often explicitly) 'wrong'. Telling a story about someone with a new idea allows their actions to be imbued with

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meaning and the change agent to be accorded positive qualities such as courage, creativity, and so on ('Mrs Fernando from the records department went in and told the consultant straight, and you should have seen the look on his face').

Fifth, stories are a vital window not only to the truths about the organisation, but also to its fictions – in which, for example, key characters are unjustifiably canonised or demonised in stories that are closer to gossip than to fact. Provided that we keep the status of these fictions in mind, they can reveal aspects of the organisation that are otherwise inaccessible to the student of its culture. Indeed, an important theoretical point to grasp is that organisations cannot be understood via the 'facts' alone. One organisational anthropologist has claimed that *'Modern institutions ... run on fictions, and the task of the scholar is to study how these fictions are created and sustained'*. Through stories, members of an organisation interpret events, infusing them with meaning by linking them in temporal (implicitly causal) sequence, and through distortions, omissions, embellishments, metaphors and other literary devices. Not only is the 'true' version of events an unhelpful concept, but also the very plasticity of stories in organisations is the key to what Gabriel has called the 'organisational dreamworld'.

Here is an example. I recently attended a seminar in which we discussed several transcripts of interviews with senior executives about the takeover of one large organisation by another. More than one interviewee had referred to the practice of counting the toilet rolls, which had (allegedly) been introduced across the board the day after the merger. In some ways it didn't matter whether the stories were 'true' (did staff members really have to account for every sheet of toilet paper?) or not. It was their choice of metaphor that was significant. The toilet-paper story perfectly symbolised the new culture of the merged organisation. Micro-management extended everywhere, even behind the locked lavatory door (perhaps the ultimate place where decent people might expect to be left in privacy). There was a performance standard for everything, including bodily functions, and staff had been told that they had failed to meet it. It wasn't just that the new management did not trust people who had given decades of faithful service to the old organisation. They were perceived to feel that long-standing senior employees had been spending too much time with their trousers down all those years. This example illustrates how the study of 'fictions' can illuminate some of the most inaccessible issues in organisational life.

One final feature of storytelling that is critical in the organisational context is its

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links to leadership. Leaders are people who tell good stories, and about whom good stories are told. A good organisational leader is one who can not only develop a vision of where the organisation is heading, but also articulate that vision in terms of an ongoing, enacted story about who we all are and where we are going, thereby '*putting the "us" in "me" and the "me" in "us"*'. Most of us know the feeling of futility and disengagement that occurs when change is imposed by means of executive letters, must-do memos and other devices for conveying top-down instructions through a bureaucracy. Most of us have also experienced the stirring in our hearts when someone we admire and respect gives a speech or writes a letter that voices a vision for change in which we feel personally and actively engaged. Every chief executive, senior partner or clinical director yearns to achieve a fraction of the personal charisma and rhetorical power used by Martin Luther King in '*I have a dream...*' or by Churchill in '*We shall fight them on the beaches...*' – and it is no accident that both of these famous speeches were composed almost entirely of stories.

In the previous chapter, I used a mainstream theoretical model (experiential learning theory) to illustrate how, and under what conditions, stories might enhance learning by individuals. In order to use stories effectively in organisational change, we must first understand change from a theoretical perspective. In classical management theory, change management is all about defining clear objectives and ensuring that these happen by (for example) appointing the right staff, providing the right training, making resources available for defined projects, and keeping everyone fixed on clear goals and milestones. According to this perspective, change is – at least implicitly – something that can be planned, put on people's job descriptions, managed proactively, and audited against predefined success criteria.

But classical management theory has been largely superseded by a number of more contemporary models of organisational change. In one such view, change is not a technical process that can (or should) be 'properly managed', but a process dependent on the construction, acquisition, transfer and use of knowledge, and on the need for the members of an organisation to make sense of change efforts by assimilating them into their cognitive schemata. Perhaps the best known writer on knowledge based views of organisations is Peter Senge, author of *The Learning Organisation*. A learning organisation is one in which the acquisition and sharing of knowledge by its members are valued and actively facilitated (for example, through seminars, informal discussions, training days, and appropriate IT infrastructure and support). The notion of organisational change as the reframing and sense making of knowledge by its members aligns with a new conceptualisation of leadership not as 'command and

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control', but as providing the opportunities and facilitation necessary for people to build and exchange knowledge. In a change effort, the leader's role is to pull a team together around a shared story of innovation, improvement and action. In practice, this means initiating and leading discussions around the *meaning* of any proposed changes.

The quote on page 101 comes from a chapter by Professor Paul Bate, who undertook an action research study to change the culture – and key patient outcomes – in a 'failing' NHS hospital trust. The quote was read out by the chief executive at a multi-professional meeting, and a collective decision to 'do something about this' was subsequently made by those attending. Group members also heard the views of various clinicians, junior and middle managers, and support staff. The group agreed to meet regularly and monitor their efforts to drive the sorts of changes which would ensure that the late David Smith's experience could not occur in the new organisation. Bate's role was to help this happen, and to document progress from both a practical and an academic perspective.

In his chapter, Bate emphasises that change was driven not by himself (the person officially hired as change facilitator) but by the collective social action of the people who had signed up to the change. How did he facilitate this? Mainly, he reflects, by encouraging the group to tell stories, and by offering alternative framings of past or present events and actions, which the other members could choose to run with or reject. In a previous book he has argued about the fundamental role of language in organisational transformation:

'If you want to change the way people think, start by changing the way they talk. You need to encourage them to devise new scripts and participate in new language games. You endeavour to shape intellectual and symbolic structures by giving people new topics of conversation to debate, gossip and fight about; and you give them new stories to tell and retell each other. The theory of change is therefore actually quite a simple one: if you can unfreeze and restructure language you can unfreeze and restructure thought ... Stories and storytelling are a crucial aspect of organisational life ... the narrative to tie experiences, views and interpretations together, something that has sequence, logic, flow and direction, that represents a coherent version of the emerging reality.'

If this model of change is taken to its logical conclusion, organisational change is not so much the product of good management as a social movement, embodied

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in the identities and actions of every member of the organisation. The most readily identifiable social movements are those (such as the feminist movement or the peace movement) that transcend organisations. But change within an organisation can also emerge from the joining together of individual energies. This phenomenon is one that a minority of NHS leaders are now explicitly seeking to capture and exploit at national level – as, for example, in the stirring monograph *Towards a Million Change Agents*.

'Social movements are constituted by the stories people tell to themselves and to one another. They reflect the deepest ways in which people understand who they are and to whom they are connected ... They are constructed from the interweaving of personal and social biographies – from the narratives people rehearse to themselves about the nature of their lives ... The construction of collective action, therefore, is inseparable from the construction of personal biography, from the ways, that is, we experience the imprecation of our individual and social selves.'

In his own account of his action research project, and in his general writings on the use of language as a tool in organisational change, Bate presents the development of organisational-level stories as an essentially benign, creative and potentially transforming force that can be captured and channelled by the astute organisational leader or change facilitator. It is worth contrasting this picture with a rather more sinister framing of organisational narrative offered by Rick Iedema and colleagues, who have considered how critical incident reporting (CIR) both reflects and shapes what they call the organisation's 'meta-discourse'.

As the airline industry has demonstrated, most disasters arise from human error in imperfect systems. Learning from errors and near misses, and implementing changes (to equipment, staff training, supervision and procedures), are crucial to prevention of similar problems in the future. In CIR, the key staff involved construct a story of what happened, allowing the incident to be analysed at a later date and the findings fed into the quality improvement cycle. The emphasis is not on whose fault the incident was, but on what can be learned from it – and especially the root causes in the system that might be modified (root cause analysis). CIR is generally presented in the literature either as a logico-deductive analytic technique for identifying and correcting flaws in the system, or as a story based professional learning tool. Iedema and colleagues propose an alternative perspective – that CIR fundamentally alters the relationship between clinician and organisation through 'the re-articulation of

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clinical failure into organisational meta-discourse. Let me try to explain what they mean by this, because it is relevant to a research technique I'm going to introduce in the next chapter.

Iredema and colleagues studied CIR in an Australian remote rescue (flying doctor) organisation. They examined 124 written CIR forms (which were structured, interestingly, under four headings – 'Story', 'Outcome', 'Steps taken or treatment required' and 'Was this incident preventable?') using a narrative theoretical lens. In broad terms, they looked for and explored the use of chronology, emplotment, literary devices, emotional comment and dialogic expression. A small proportion of CIR reports seemed explicitly to reject the narrative form by (for example) using telegraphic structure instead of full sentences, lists instead of chronology, passive instead of active voice, and nominalisation rather than verbs (for example, 'demise' rather than 'died'). They found that such a format depersonalised the incident and framed the analysis as a technical study of flaws in system components. But much more commonly, the author used narrative techniques to a greater or lesser extent. In particular, the reports became vivid (and often very moving) stories through the use of chronology, the active voice, dialogism (for example, 'Should I have put a line up at that point?') and insertion of evaluative comments, including personal affect ('I felt angry'), judgements about people ('local doctor had refused to attend') and assessment of contextual factors ('very long distances were involved').

In some examples, narrativising the report appeared to lead successfully to a holistic, no-blame analysis of the problem and the identification of areas for improvement. But in other examples, the more the CIR approximated to the narrative form, the less 'root cause analysis' could be tracked back purely to aspects of the system that could be tweaked. Rather, it exposed interpersonal, inter-professional and inter-organisational tensions that had no easy or universally acceptable solution. In the authors' words, *'narrative confession and mutual scrutiny amongst clinicians need not always produce encouraging outcomes and may give rise to suspicion, resentment and contestation'*.

The study described above was undertaken in a particular social and historical context of increased public and professional awareness of risk and harm in medical care, a rapidly growing culture of managerialism (and the expectation that clinicians should become involved in management), and the increasingly explicit links between the ethical behaviour of doctors and the organisation and management of healthcare (for example, in clinical governance). Applying Foucault's notion of governmentality (i.e. the internalisation and enactment of constraints of state and system by

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professionals), the authors argue that the expectation of narrativising of errors in the CIR format puts pressure on doctors to merge their own professional and ethical reflections with organisational norms and expectations, thus blurring the boundary between private and public, individual and state, and clinician and manager. What used to be discussed in confidence (and often informally and 'off the record') between doctors is now a compulsory confessional, recorded in structured CIR format and systematically scrutinised by inter-professional teams through a lens of norms, values, power structures and precedents developed at organisational level (this is what ledema and colleagues have termed 'organisational meta-discourse').

ledema and colleagues describe the current era of organisational development as 'post-bureaucracy'. Healthcare organisations have gone beyond the impersonal roles and lines of accountability depicted on the traditional organisational chart, and – as illustrated by the 'confessional' critical incident report – have entered a period in which staff are expected to achieve a deeper level of interrelating and communicating than that explicitly called for on their job description. Whether this is a good thing or not is likely to depend on the particularities of the case and the context. I shall return to this example in the next chapter, when I use it as an example of a research technique called discourse analysis.

You may or may not agree with Paul Bate that a change facilitator can drive transformation in an organisation by inviting its members to tell different stories to one another, or with Rick ledema's reframing of critical incident reporting as encroachment of the state and system upon professional identity and practice. But both of these examples should illustrate how a narrative perspective can help us to look at the healthcare organisation in a new light. Through a narrative lens, the organisation moves beyond its traditional image – it ceases to be a machine in which we are all cogs – and becomes (in the first example) a collection of what Charles Handy might call 'resourceful humans' engaged in what Victor Turner would call an unfolding social drama, or (in the second example) an overarching set of power relationships and expectations that all of its members internalise, are shaped and constrained by, and – unwittingly and unconsciously – help to perpetuate.

It is a shame, then, that narrative approaches to organisational studies are currently seen as marginal rather than central in the prevailing political climate – which might be summed up in the New Labour slogan 'what matters is what works'. The 'make it happen' mindset of the new public management requires the setting of explicit performance outputs, and depressingly often restricts the focus of both 'quality

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assurance' and 'research' to establishing the efficiency and cost-effectiveness with which these predefined outputs are achieved. The unpredictable nature of stories, their refusal to be standardised and their tendency to trigger the creative imagination of tellers and listeners make them slippery and frustrating tools when organisational success is defined in such terms. In general, top-down, centralised and managerially driven approaches to organisational change seek to minimise the use of stories and replace them with something more explicit, controllable and auditable (such as an algorithm, protocol or guideline). In the next section I shall describe an example of this tendency which, more than a year after the event, still keeps me awake at night.

The UK Department of Health funds two National Confidential Enquiries every year – into maternal and child health (deaths during pregnancy and in young babies) and into patient outcome and death (serious complications from surgical operations). All health regions are required to submit detailed case reports of any such deaths, and the reasons for the deaths are considered in strict confidence by a multi-professional panel. Traditionally, these reports have been illustrated by case vignettes – stories told by doctors and nurses about the people who died, written in traditional medical jargon and style ('A 29-year old primigravida was admitted in the second stage of labour, complaining of a feeling of dizziness ...', etc.). In 2003, the National Institute for Clinical Excellence (NICE) took over responsibility for the Confidential Enquiries (which hitherto had run themselves as quasi-autonomous professional groupings). In 2004, as part of a wider drive towards a more 'evidence-based' approach to healthcare, and also because of concerns about confidentiality and the ethics of consent, a group of senior decision makers at NICE announced provisional plans to rid the Confidential Enquiries of patients' stories.

Clinicians weren't sure that this was a good idea, and I was invited to join a group of them in trying to persuade NICE to change its mind. Stories, we argued, were invariably the most interesting parts of an otherwise dimly dull document. Reading a story about a real 29-year old woman who had died of a real postpartum haemorrhage provided a far more salutary lesson for clinical staff and managers than an algorithm that stated what action to take when a hypothetical patient's blood pressure drops below X. But the argument was made that stories about individuals are always anecdotal, and hence might 'bias' the reader through the distortions inherent in the story form. Far better to let the experts distil out the key points for individuals (for example, what skills professionals should have) and organisations (for example, what equipment should be available) and list them as a clear set of bullet points. Finally, suggested an adviser at NICE, stories are only really useful if

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they are employed to make a very simple point, otherwise the reader may get lost in idiosyncratic and irrelevant detail.

Several of us disagreed with this. Stories, as I have argued elsewhere in this book, are useful for precisely the opposite reasons – they embrace complexity, they elude simple, rational explanations, and their contribution to the debate can rarely be reduced to bullet points. A consultant obstetrician told the story of a teenage girl who had frozen to death in the grounds of a hospital after being discharged late in the afternoon following a miscarriage. Apparently no one – or at least no one on duty at the time – had known that this unfortunate young woman did not have a home to go back to. What is the ‘clear learning point’ of this case? What is the ‘simple message for the organisation’? What instruction, algorithm or risk management protocol might meaningfully replace this story?

The answer is that the story will have different meanings – and different learning points – for different individuals (those with different clinical and management roles in the NHS, social workers, police) and different organisations (hospitals, primary care organisations, advocacy groups). If we were to release this story (for example, by publishing it in the *British Medical Journal*, or even in *The Sun*), I predict that it would be shared, and its meaning negotiated, in a thousand different ways in organisations up and down the country, from the boardroom to the locker room, by people who have been moved by the tragedy and want to do something to prevent a comparable one from occurring locally. The more the story is told in different contexts and settings, the greater will be the diversity of triggers to collective action. And the more likely one group is to come up with a transferable good idea for meeting the needs of disempowered and vulnerable patients.

In April 2005, responsibility for the Confidential Enquiries was taken over by the National Patient Safety Agency (NPSA), who produced a policy on the use of vignettes in October 2005. This policy acknowledged the previously mixed opinion on the use of vignettes, and emphasised that the NPSA upheld the general principle of using stories for illustrative purposes. The authors cautioned against the indiscriminate inclusion of vignettes, which might prove ‘dangerous’. According to the policy, vignettes should mainly be used to illustrate commonly occurring scenarios for which there is good evidence for a particular ‘best practice’. ‘Lengthy, drifting, unstructured or repetitive text’ was also discouraged. This policy, although far more accommodating than we had feared after the 2004 meeting at NICE, is still somewhat ambivalent about the usefulness of stories – especially when balanced against their

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'dangers'. Whatever the next instalment in this particular policy story may be, I hope that someone, somewhere, will have the foresight to allocate funds for systematic research into the use of vignettes in policy documents. Which brings me to the chapter on narrative research.

CHAPTER

6

THE CONTRIBUTION OF PRIMARY CARE RESEARCH TO EDUCATION, TRAINING AND DEVELOPMENT OF THE PRIMARY HEALTHCARE WORKFORCE



This chapter is excerpted from
International Perspectives on Primary Care Research
By Felicity Goodyear-Smith, Bob Mash

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THE CONTRIBUTION OF PRIMARY CARE RESEARCH TO EDUCATION, TRAINING AND DEVELOPMENT OF THE PRIMARY HEALTHCARE WORKFORCE

Wim Peersman and Jan De Maeseneer

Excerpted from *International Perspectives on Primary Care Research*

INTRODUCTION: HUMAN RESOURCES AND EDUCATIONAL RESEARCH

Human resources are key in the development of policies to strengthen primary healthcare (PHC) systems worldwide. In their 2009 editorial 'Renewed focus on primary health care (PHC)' in *Education for Health*, Glasser and Pathman emphasise the need for research on PHC education.

Educational research on human resources has to take into account the framework offered by the report 'Health professionals for a new century: transforming education to strengthen health systems in an interdependent world'. In the previous century, research mainly focused on assessment of problem-based learning and disciplinarily integrated curricula. Didactical innovations were evaluated, including the use of standardised patients to assess a student's clinical practice, the impact of earlier student exposure to patients and the expansion of training sites from hospitals to communities. The majority of this research was conducted in high-income countries, and only a few studies documented developments in low and middle-income countries (LMICs).

The Lancet Commission indicates that, in the twenty-first century, a third generation of reforms is needed that should be system based to improve the performance of health systems by adapting core professional competencies to specific contexts, while drawing on global knowledge. The realisation of this vision will require reforms with two important outcomes: transformative learning and interdependence in education. 'Transformative learning' is about developing leadership attributes with the intention to produce change agents. 'Interdependence' is a key element in a systems approach and involves three fundamental shifts: from isolated educational programmes to programmes harmonised with health systems; from stand-alone institutions to networks; and from inward-looking institutional preoccupations to harnessing global flows of educational content, teaching resources and innovations.

The challenge nowadays is to start using the framework of this third generation of reforms to formulate new research questions that will also require new methodological approaches, such as mixed methods and participatory action research. PHC represents an important field of research in order to test the third-generation reforms: experiences such as community-based education and service (COBES) create opportunities to evaluate how educational innovation has made undergraduate and postgraduate medical training more relevant to the needs of PHC. The Network: Towards Unity For Health has documented the evaluation of many of these community-based educational initiatives. The Training for Health

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Equity Network also uses a systems perspective, looking at ways to increase social accountability and reorient educational programmes towards the needs of society.

BOX 6.1 RECOMMENDATIONS TO TRANSFORM AND SCALE UP HEALTH PROFESSIONALS' EDUCATION AND TRAINING (SELECTION)

- Health professionals' education and training institutions should consider designing and implementing continuous development programmes for faculty and teaching staff relevant to the evolving health-care needs of their communities.
- Health professionals' education and training institutions should consider innovative expansion of faculty, through the recruitment of community-based clinicians and health workers as educators.
- Health professionals' education and training institutions should consider adapting curricula to the evolving healthcare needs of their communities.
- Health professionals' education and training institutions should use simulation methods (high fidelity methods in settings with appropriate resources and lower fidelity methods in resource limited settings) of contextually appropriate fidelity levels in the education of health professionals.
- Health professionals' education and training institutions should consider using targeted admissions policies to increase the socioeconomic, ethnic and geographical diversity of students.
- Health professionals' education and training institutions should consider implementing interprofessional education (IPE) in both undergraduate and postgraduate programmes.
- National governments should introduce accreditation of health professionals' education where it does not exist and strengthen it where it does exist.
- Health professionals' education and training institutions should consider implementing continuous professional development and in-service training of health professionals relevant to the evolving healthcare needs of their communities.

The *Transforming and Scaling Up Health Professionals' Education and Training* guidelines from WHO summarise the current evidence in relation to the evaluation of health professional education in recommendations across five domains: education

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and training institutions, accreditation and regulation, financing and sustainability, monitoring and evaluating, and governance and planning (**Box 6.1**).

In this chapter we illustrate, using the example of the Human Resources for African Primary Health Care (HURAPRIM) project, how primary care research can help tackle human resource issues from a systems perspective, focusing on brain drain, problems with access, need for optimisation of service delivery, importance of task-shifting and competency sharing. The chapter ends with a reflection on social accountability and dissemination, extremely relevant for this type of research, and finally, formulates a critical reflection on 'societal impact'.

ADDRESSING THE HUMAN RESOURCES CRISIS: THE HURAPRIM ACTION-RESEARCH PROJECT

In 2011, the HURAPRIM project started looking at the challenge of recruitment, training and retention of human resources for African PHC. In this section, we describe the aims of the HURAPRIM project, explore the research questions and describe the different interventions as an illustration of how primary care research can contribute to the development of an appropriate health workforce for the health system.

AIMS OF THE HURAPRIM PROJECT

Several reports have documented the huge deficit of human resources for health (HRH) in Africa. The causes are multiple and relate to a combination of underproduction, internal maldistribution, inappropriate task allocation, working conditions and brain drain. The main objective of the HURAPRIM project was to analyse the actual situation of HRH in Africa and to understand the complexity of the causes for the actual shortages in PHC. Based on these results, the project developed innovative interventions, strategies and policies to address the HRH crisis in sub-Saharan Africa and evaluated those interventions, strategies and policies. Five African countries were involved (Mali, Sudan, Uganda, Botswana and South Africa), representing Africa's broad diversity.

RESEARCH METHODS USED FOR THE HURAPRIM PROJECT

First, the project assessed the scope of the deficit in HRH in Africa and identified and analysed its main causes, with special emphasis on PHC in rural areas and underserved urban areas. The research tasks for this objective consisted of four components:

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1. A literature review (including grey literature) on the availability of health workers in the participating African countries, compared with what would be needed to provide access to healthcare for the relevant populations.
2. Participatory research with stakeholders in selected districts of the included African countries to determine what human resources were currently available in the health sector, what gaps existed in service provision, what the reasons were for the deficit in human resources, which interventions had already been tried and ideas for new interventions.
3. A confidential enquiry into maternal and child deaths in Mali and Uganda. This approach consisted of an independent review of a series of deaths that explicitly avoided attributing blame to individuals but attempted to identify modifiable system failures. The cases were summarised and presented to a panel of local health workers (nurses, general practitioners and hospital specialists) and community representatives, with the aim of prioritising how human resources for health could best be used to reduce maternal and child mortality.
4. Semi-structured interviews with migrant health workers in partner countries that receive migrant health workers (UK, Belgium and Austria in Europe, and South Africa and Botswana in Africa) to find out their reasons for migration (push and pull factors), what might motivate them to return to their country of origin to work in the health sector and to get their perspective on reasons for the lack of health workers in Africa.

Based on the results of this first phase, the following interventions were developed, implemented, monitored and evaluated in the participating African countries.

PRIMARY HEALTHCARE RE-ENGINEERING, INCLUDING PRIMARY HEALTHCARE OUTREACH TEAMS, AS A HUMAN RESOURCES STRATEGY IN SOUTH AFRICA

In South Africa, the Chiawelo Community Practice developed a community-oriented primary care model, coordinated by a family physician, that was based on PHC outreach teams consisting of community health workers led by professional nurses. This offered an opportunity to explore the development of integrated PHC teamwork in South Africa. To translate the research into action, the participatory action research method was used. This method included qualitative and quantitative approaches but was, above all, participative. The key advantage of using an action research method was that it drew attention to how an intervention unfolds and how the actions of an intervention can mutually benefit a community of practitioners.

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CONFIDENTIAL ENQUIRY IN UGANDA AND MALI AS ACTION RESEARCH AIMED AT IMPROVING QUALITY OF PRIMARY HEALTHCARE DELIVERY

The aim of this intervention was to refine the confidential enquiry process into a tool that could be scaled up and used both to improve quality of human resources and to prioritise and advocate for more human resources in areas of greatest need. The process included a strong element of dissemination of results at all levels from the community to health workers to politicians. The primary outcome measure was the number of child (under 5 years) deaths in the selected sub-counties in year 2 compared with in year 1. From this, and official statistics on populations of the sub-counties, and estimated birth rates, it was also possible to estimate the under-5 mortality rate. Secondary outcome measures included implementation of recommendations to improve quality. In addition, focus groups discussions with participants and in-depth interviews with key stakeholders were conducted on how they evaluated the intervention.

STRENGTHENING OF THE SUPPORTIVE SUPERVISORY CAPACITY OF PRIMARY CARE TEAMS VIA THE DISTRICT HEALTH MANAGEMENT TEAM AND MID-LEVEL HEALTH MANAGERS IN BOTSWANA

A cooperative inquiry group (CIG) was used to build the supportive supervision practice of the district health management teams (DHMTs) and cluster heads. The use of the CIG method falls within the participatory action research paradigm. The CIG was composed of the DHMT and mid-level health managers in the district (cluster heads). The aim of the intervention was to explore whether strengthening the supportive supervisory practice of the DHMT and mid-level health managers could improve retention of PHC workers. A survey was also used to evaluate changes in healthcare workers' motivation to remain in PHC and in their perceptions of organisational culture and to compare this with a non-intervention district.

PROMOTING COOPERATION BETWEEN WESTERN SCHOOLED AND TRADITIONAL PRIMARY HEALTHCARE WORKERS IN MALI

The main objective was to reduce maternal and neonatal mortality, and to promote low-risk motherhood, by an organised and evaluated collaboration between traditional and modern health systems through participatory action research. More specifically, traditional birth attendants were involved in the management of obstetric emergencies and in the promotion of low-risk motherhood. Another objective was to define and set up a sustainable and participatory village-level data collection and

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reporting process on maternal and neonatal health by strengthening the local health information system.

ETHICAL CONSIDERATIONS

During all the research activities, the major ethical challenges related to brain drain and the human resource crisis in African PHC were identified to design an ethical framework that could be used to stimulate the ethical debate on human resources for health.

SOCIAL ACCOUNTABILITY AND DISSEMINATION

Scientific work on human resources for African PHC is not a 'neutral' exercise and confronts researchers with the societal need to provide 'scientific evidence' in the midst of important debates. In 2012, there was a debate in the Ugandan parliament, with many MPs initially insisting they would not pass the national budget if the government did not reverse its plan to reduce health expenditure. However, according to the 2012/2013 national budget framework paper, the health ministry budget was going to be reduced substantially.

Primary care researchers of HURAPRIM, in cooperation with the Department of Family Medicine of Mbarara University of Science and Technology, decided to provide a four-page informative document entitled 'Why Uganda needs to increase its health budget: a briefing for MPs', summarising the evidence and documenting the actual challenges – for example, the death of too many mothers and children in Uganda. After the debate, the government announced that it would double the monthly pay for doctors in level IV health centres and would spend extra money to recruit 6172 health workers.

Apart from these 'contextual opportunities' to disseminate findings, an active strategy using a variety of media is necessary. For example, in May 2015, a short document entitled 'Supporting family practice in Africa', based on the HURAPRIM project, was published by the European Commission (**Box 6.2**).

BOX 6.2 'SUPPORTING FAMILY PRACTICE IN AFRICA'

What good is an empty clinic? The brain drain that is depleting healthcare services in many parts of Africa is leaving entire communities stranded. An EU-funded project is looking into ways to mobilise more human resources for primary healthcare across the continent.

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The HURAPRIM project focuses on primary healthcare in Africa. It strives to shed new light on the reasons why the human resources required to run these services are hard to recruit and retain and aims to identify strategies that could help to turn the situation around.

Due to end in May 2015, the HURAPRIM project – implemented jointly by partner organisations in Austria, Belgium, Botswana, Mali, Sudan, South Africa, Uganda and the United Kingdom – has analysed the motivations of health workers who have decided to migrate and the impact of these departures on public health. It has also taken steps to raise awareness of the importance of primary healthcare services, highlighted promising strategies to boost human resources in frontline services and issued recommendations for policymakers.

Treating the brain drain

While many healthcare workers leave to work in other continents, says project coordinator Jan De Maeseneer of Ghent University, there is also a brain drain phenomenon within Africa. Human resources are moving from rural areas to the cities, from primary care to specialty care, from the public service to private services, and from general healthcare to programmes focusing on specific diseases such as HIV/AIDS, he explains.

‘There are economic and political elements that determine the fact that people migrate: difficult work conditions, low salaries, and very high workloads,’ De Maeseneer notes. Economic conditions are of course an important factor, he explains, but many people emigrate for other reasons – to specialise in a particular field, for example, to escape political instability or insecurity, or to join family members who are already living abroad.

These are understandable personal decisions, often taken in very difficult circumstances, says De Maeseneer. Strategies to counter the phenomenon need to focus on structural solutions that boost health workers’ options at home.

Addressing the problem is not simply a matter of money, De Maeseneer explains, although of course adequate financial resources are needed. Training health workers in their own country would, for example, already solve part of the problem. While a number of African countries have excellent facilities in place to train prospective health workers, others do not – and persons who have already left for their studies often decide to remain abroad.

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Specific strategies to support family practice in underserved areas would be another option. Medical graduates willing to work in remote rural locations could receive additional training and support over the internet, for example, enabling them to build up the required skills and autonomy.

A healthcare emergency

HURAPRIM looked into the causes of brain drain, but it also examined the consequences – for example by means of ‘virtual autopsies’ of children deceased under the age of five. The researchers interviewed the families and health workers involved in a number of cases and concluded that most of these tragedies could have been prevented. Where primary healthcare is unavailable or underskilled, lives are lost.

Armed with this information, HURAPRIM was able to document this fact in its interaction with policy-makers. ‘In the places where we did this kind of intervention, deaths decreased in the following years,’ De Maeseneer reports.

Be fair

HURAPRIM is preparing a list of recommendations for policy-makers both in Africa and abroad. Indeed, countries recruiting health workers from less affluent countries also bear part of the responsibility, says De Maeseneer.

This observation shapes one of HURAPRIM’s key messages. ‘The international community should agree that if you integrate a doctor or a nurse that was trained in a developing country in your health system in the West, you should reimburse the full cost of training that person to the country of origin,’ De Maeseneer explains.

The amount of this refund should correspond to the much higher cost of training such a person in the recruiting country, he adds. This approach would enable countries of origin to train several people for every person that has left. ‘This is the least we should do if we take advantage of the training people received elsewhere,’ De Maeseneer concludes.

CONCLUSION

We have used the experience of the HURAPRIM project to illustrate the need for a comprehensive research approach when it comes to the important human resource challenges in African PHC. This African experience can be broadened

THE CONTRIBUTION OF PRIMARY CARE RESEARCH

TO EDUCATION, TRAINING AND DEVELOPMENT OF THE PRIMARY HEALTHCARE WORKFORCE

Wim Peersman and Jan De Maeseneer

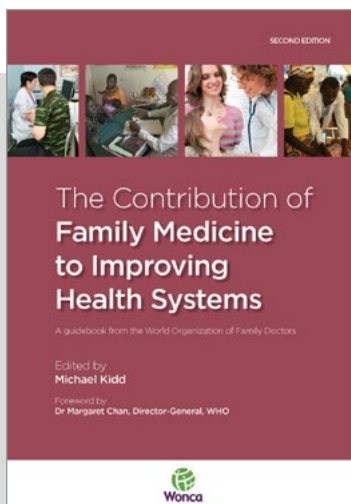
Excerpted from *International Perspectives on Primary Care Research*

to an international context and educational primary care research can be one of the strategies to address human resource problems. Action research and the use of mixed methods are useful approaches to addressing the reforms outlined in the report of The Lancet Commission. Integration of a systems perspective in the research will also avoid the risk of jumping to simple (but incomplete) one-dimensional conclusions. Involving the broader societal context is essential. Moreover, it is important that researchers use appropriate ways to disseminate the findings of the research to increase the social accountability of scientific work and contribute to 'societal impact'.

CHAPTER

7

CREATING A SUPPORTIVE ENVIRONMENT FOR OPTIMAL FAMILY PRACTICE



This chapter is excerpted from
*The Contribution of Family Medicine
to Improving Health Systems:
A Guidebook from the World Organization of Family Doctors*

By Michael Kidd

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CREATING A SUPPORTIVE ENVIRONMENT FOR OPTIMAL FAMILY PRACTICE

Michael Kidd

Excerpted from *The Contribution of Family Medicine to Improving Health Systems*

Family doctors need supportive environments to enable them to care for individuals, families, and communities. Many conditions are necessary for the success of family practice (see **Table 7.1**). Necessary education and training prepares family doctors, while effective health systems and collaborative teams provide the organizational structure necessary for the delivery of efficient health services. Supportive environments make it possible for family doctors to provide the highest-quality health care with available resources.

Table 7.1 • Key conditions for optimal family practice

Component	Examples
Relationships	Effective communication and collaboration with patients, families, communities, health teams, specialty professional associations, academic medical centers, government and public health authorities, and professional associations
Education	High-quality education provided through medical school, specialty training, and continuing education
Health teams and systems	Primary care teams provided with adequate resources, sufficient numbers of health professionals, and collaborative practice models
Professional associations	Standards established for high-quality family medicine, needs assessments conducted, examination and certification in place, adequate resources secured, public educated about the role and value of family doctors, productive collaboration with national and international organizations
Primary care research	Sufficient funding provided for family medicine researchers to generate new knowledge, knowledge applied to improve the quality and assess outcomes of care
Quality improvement	Family doctors possess knowledge and skills to assess quality and to improve clinical processes and outcomes
Policy and financing	Incentives provided to support high-quality primary care for the entire population

This chapter covers components of supportive environments necessary for high-quality family practice. These include promoting positive relationships; developing professional organizations; financing and rewarding optimal practice; improving access; supporting primary care research; enhancing the quality and outcomes of practice; and strategic planning for family medicine development. Each of these interrelated components contributes to supportive family practice environments.

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7.1 PROMOTING POSITIVE RELATIONSHIPS

While the components listed in **Table 7.1** contribute to conditions for optimal practice, the well-regarded image of a well-trained family doctor results from positive relationships developed over time with patients and the public, health professional colleagues, academic facilities, and health authorities. Relationships with these health system stakeholders are based on family doctors' provision of high-quality patient care, effective collaboration with primary care team members and other specialty colleagues, and dedicated service to communities. Promoting such positive relationships begins by understanding and addressing the needs and the potential underlying resistance of each stakeholder.

RELATIONSHIPS WITH INDIVIDUALS AND THE COMMUNITY

Relationships between family doctors and their patients, colleagues, and the community affect the climate for continued growth and development of family medicine as a discipline. As an example, the Canadian health system has undergone transformation to strengthen primary care delivery in the past decade, with encouragement, engagement, and collaboration with all stakeholders including patients, providers, and policy makers, as an essential part of the reforms.

In another example, in 2010, the president of the United States signed into law that country's most comprehensive health reform package since 1967. The Patient Protection and Affordable Care Act (ACA) will assure health insurance coverage to more than 30 million previously uninsured Americans. The ACA and the Congressional testimony that underpinned it, focus heavily on primary care as being essential and important to reducing costs. This law should help bring family physicians closer to more members of the population of the United States.

When introducing family medicine in a country, the public may first need to be educated about the role of the family doctor in the health care system. In some countries in which general practitioners are inadequately trained, over-worked, and under-rewarded, the public may have a negative opinion about the family doctor as personal physician. In this situation, it may be essential for governments or the private sector to fund family medicine development and support model practices to demonstrate to the public that well-trained family doctors can provide high-quality care with high patient satisfaction.

In situations where family physicians have substantial control over referral to other medical specialist services, and are pressured by their employers or the government

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to restrict such access, patients and the public may voice unhappiness with restricted access. Such a situation already exists, for example in the United Kingdom, where proposed reforms would move toward a more market-driven system with general practitioners acting as payers for specialist care and controlling 70% of the National Health Service budget. These situations require careful monitoring to ensure that family doctors are able to continue to serve as effective patient advocates.

In reality, the public is often quite appreciative of the primary care services provided by family doctors. Treating patients promptly and courteously enhances public acceptance. When individuals find they can depend on their family doctor and local health team to serve as competent providers and advocates, family doctors and members of the entire primary care team become highly regarded members of the community. In addition, if family doctors work collaboratively with others on community health improvement projects, either as paid or as volunteer contributors, they are perceived as willing to work for the well-being of the entire community. As a result, they may be invited to act as community health advocates and leaders to contribute to other health-related programs such as planning for economic development, education, or safety. Such leadership roles enhance the value of family doctors to the whole community.

Family physicians can engage in a strategy of community-oriented primary health care (COPC). Starting from experiences in daily practice, complemented by epidemiological data, the primary care team, together with the local community, can formulate a "Community Diagnosis," and start action to address the causes that lead to ill health.

Family doctors can contribute to public health education. Activities may include writing newspaper columns, participating in radio talk shows, and providing televised updates on current health topics. To enhance their image, family doctors and their representative organizations can develop successful public education campaigns using advertisements, posters, and brochures to promote the perception of the family doctor as a personal and caring doctor. Such campaigns can emphasize the advantages of having one doctor to provide comprehensive health care to individuals and families and to coordinate all health care needs. Raising awareness of the characteristics and functions of family medicine instills public confidence in the quality of care provided. Strategies to promote positive relationships with local communities are listed in **Box 7.1**.

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BOX 7.1 HOW FAMILY DOCTORS CAN PROMOTE POSITIVE RELATIONSHIPS WITH THE COMMUNITY

Family doctors may:

- provide high-quality, accessible, comprehensive health care services
- provide continuity of care
- provide people-centered care
- treat patients and families promptly, courteously, and with sensitivity to their health care needs and concerns
- act as patient advocates
- engage with community leaders and health advocates to the benefit of their communities
- participate in community health improvement programs
- participate in volunteer services
- deliver public health education
- develop public information materials

RELATIONSHIPS WITH COLLEAGUES

Positive relationships between family doctors, health team members, and colleagues provide a foundation for effective partnerships. A number of groups of health professionals may be affected by the development of family medicine. These groups may include practicing generalist physicians who were not trained as family doctors, other specialists, and allied health professionals. Many of these professionals may be involved in primary care delivery and share the goals of family doctors. Some may question the need for family doctors or fear for their own survival.

Addressing these concerns, negotiating the complementary roles of family doctors and other health professionals, and inviting others to participate in the development of family medicine will help build alliances to deliver effective primary care. Strategies may include retraining practicing specialist physicians who wish to become family doctors, or developing new practice models that integrate family doctors with other health professionals.

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In coordinated health systems, the roles of family doctors and other health professionals are complementary; each enables the other to be optimally effective. Family doctors may rely on primary care team members to provide services such as screening, health education, and treatment of chronic conditions. Reciprocal, supportive relationships among primary care team members enhance the effectiveness of the entire team.

Where family doctors assume greater responsibilities for the community or for public health, especially when they coordinate services for a given target population, they are even more dependent on a variety of allied health professionals. While trained family doctors are able to handle the majority of individual health problems in a community, they are also aware of their limitations, and know when and how to ask for help from other specialist colleagues.

When specialty physicians are appropriately consulted and share in the care of patients with complex needs, they come to understand and respect the value of the family doctor in patient care. Appropriate consultation includes providing the consultant with important background information about the patient, outlining the problems for the consultant to address, and determining the roles of the family doctor and the consultant in the continuing care of the patient.

Coordination of care is especially important when a patient is hospitalized. Some family doctors provide hospital care. Even if another physician is responsible for hospital care, the family doctor is responsible for referral and follow-up of the hospitalized patient.

Such recognition, discussion, and negotiation of the complementary roles of family doctors and other health professionals in the care of patients minimizes competition and promotes collaboration. Other specialists who work collaboratively with family doctors may become important allies in the development of the specialty. Strategies to promote positive relationships with colleagues are listed in **Box 7.2**.

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BOX 7.2 HOW FAMILY DOCTORS CAN PROMOTE POSITIVE RELATIONSHIPS WITH COLLEAGUES

Family doctors may:

- serve as collaborative team members
- communicate directly and effectively with consultant specialists
- share information to better address priority health needs
- coordinate the admission, care, and discharge of hospitalized patients
- identify problems and develop strategies to improve coordination of care
- provide continuing education programs for allied health professionals
- invite specialty colleagues to participate in teaching and continuing education programs

RELATIONSHIPS WITH MEDICAL SCHOOLS

Many medical schools have discovered that family medicine departments play important roles in their school and local academic medical centers in the areas of teaching, research, and clinical care. Initially, however, some faculty or departments may resist the introduction of family medicine.

Visits and presentations by faculty and heads of departments from places where family medicine is well established and respected may lend a more favourable attitude toward the specialty. Often, a medical school dean or respected head of department of another specialty may be a key ally in establishing family medicine in an academic medical center or medical school.

Community-based family doctors can enhance their relationships with academic medical centers and medical schools by serving as valuable clinicians, teachers, and role models for medical students and doctors in specialty training. Community-based learning experiences provide benefits for students, doctors-in-training, and the supervising doctors. When learners work under the supervision of community-based family doctors, they are able to appreciate the value and complexity of high quality, comprehensive primary care. Community-based family doctors who serve as teachers are generally motivated to deliver high-quality services, and are stimulated by interactions with eager learners. The quality of patient care is improved when family doctors participate in primary care research efforts and in continuing

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education to keep up to date and further improve their teaching skills. When family doctors are recognized and rewarded as teachers, their image is enhanced. Considerations for improving family doctors' relationships with medical schools and academic medical centers are listed in **Box 7.3**.

BOX 7.3 HOW FAMILY DOCTORS CAN PROMOTE POSITIVE RELATIONSHIPS WITH MEDICAL SCHOOLS AND ACADEMIC MEDICAL CENTERS

Family doctors may:

- serve as full-time faculty in medical school departments of family medicine
- serve on medical school admissions committees
- help teach family medicine to medical students
- serve as clinician teachers to doctors in training
- teach or participate in continuing education programs
- engage in primary care research
- enhance the social accountability of academic institutions

RELATIONSHIPS WITH HEALTH AUTHORITIES

Supportive relationships with government authorities responsible for planning and financing health care will enhance the abilities of family doctors to serve communities and the potential for family medicine to become a driving force in health reform processes. Among the factors influencing the development of family medicine, ideological and financial support from government is the most important. History shows that once this is obtained, progress is usually rapid. Governments and health authorities need to be provided with the accumulating evidence that enhancing the contribution of family medicine will help health systems provide high-quality, equitable, cost-effective care. Government health officials may be able to provide valuable information for health planning efforts, and often welcome partnerships with local physicians (see **Box 7.4**).

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BOX 7.4 PARTNERSHIPS BETWEEN THE GOVERNMENT AND FAMILY MEDICINE IN THE PHILIPPINES

The Philippine Academy of Family Physicians (PAFP), the Philippine Society of Teachers of Family Medicine and the Department of Family and Community Medicine at the University of the Philippines have collaborated with the national government and its implementation arm, the Philippine Health Insurance Corporation, on a variety of projects designed to enhance family medicine and improve quality of care.

The National Health Insurance Law, enacted in 1994, helped to formalize the role of the family doctor. Key components of this law include:

- universal access for both ambulatory care and hospitalizations
- classification of family doctors as specialists with corresponding payment for their services
- specialty referrals through family doctors
- provision for quality assurance programs to improve practice.

Projects included joint workshops on competencies, development of evidence-based clinical practice guidelines for commonly encountered conditions in primary care, research to improve access and quality of care, and pilot projects dealing with the delivery of hospice care, family wellness, and care of the disadvantaged.

Continuing medical education is required by the Professional Regulations Commission in order for family doctors to renew their licences and maintain their practicing status. The PAFP now requires participation in quality assurance activities in order for family doctors to maintain active membership. Quality improvement has also been enhanced by assistance from the World Organization of Family Doctors Working Party on Quality in Family Medicine.

Thus a mutually beneficial relationship continues to evolve. With the assistance of government support and stature, family doctors have pursued a variety of measures that assure society of the quality of their care.

Collaborative relationships between family doctors and local public health officials provide opportunities to strengthen the links between clinical medicine and community health. Strategies to promote positive relationships with health authorities are listed in **Box 7.5**.

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BOX 7.5 HOW FAMILY DOCTORS CAN PROMOTE POSITIVE RELATIONSHIPS WITH GOVERNMENT HEALTH AUTHORITIES

Family doctors:

- engage in dialogue about options for health sector reform
- participate in government health planning to improve primary health care
- communicate with health authorities to share health information for local, regional or national planning
- participate in disease surveillance and community prevention efforts
- serve as district medical officers, public health officials or public service officers
- work with professional associations to advocate optimal conditions for family practice

While each of these relationships forms an essential foundation for high-quality family practice, many other conditions contribute to the professional development of family doctors. **Boxes 7.6, 7.7, 7.8, 7.9, and 7.10** list initiatives from different countries that have supported the development of positive relationships.

BOX 7.6 HOW NEW ZEALAND PROVIDES A CENTRAL GOVERNMENT-DRIVEN, TAX FUNDED HEALTH SYSTEM WITH THE GOVERNMENT AS DOMINANT PAYER AND WITH SUPPORT PROVIDED BY NETWORK ORGANIZATIONS

Networks provide:

- administration
- budget holding
- incentivized programs
- data feedback
- peer review
- education
- human relations
- health information technology support and resources.

Networks are similarly important in many other countries and are an important way of providing a supportive environment for practicing family medicine, with a team-based and patient-centered approach

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BOX 7.7 HOW PRIMARY HEALTH CARE IN AUSTRALIA HAS BEEN REFORMED BY THE ESTABLISHMENT OF LOCAL PRIMARY HEALTH CARE ORGANIZATIONS

These organizations have supported the further development of the Australian primary health care system by:

- supporting the roll-out of initiatives including national practice accreditation
- a focus on quality improvement
- expansion of multidisciplinary teams into general practice
- regional integration
- information technology adoption
- improved access to care

BOX 7.8 GENERAL PRACTICE IS THE CORNERSTONE OF DANISH PRIMARY HEALTH CARE

It is characterized by five key components:

1. a list system, with an average of close to 1600 persons on the list of a typical general practitioner (GP)
2. the GP as gatekeeper and first-line provider in the sense that a referral from a GP is required for most office-based specialists and always for inpatient and outpatient hospital treatment
3. an after-hours system staffed by GPs on a rota basis
4. a mixed capitation and fee-for-service system
7. GPs are self-employed, working on contract for the public funder based on a national agreement that details not only services and reimbursement but also opening hours and required postgraduate education

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BOX 7.9 CANADIAN PROVINCIAL AND TERRITORIAL HEALTH SYSTEMS HAVE TAKEN DIVERSE APPROACHES TO STRENGTHENING PRIMARY CARE DELIVERY

The range of primary care reform initiatives implemented across Canada target:

- organizational infrastructure
- provider payment
- health care workforce
- quality and safety.

Primary care teams and networks in which multiple physicians work in concert with other providers have become widespread in some provinces. They vary on a number of dimensions, including:

- physician payment
- incorporation of other providers
- formal enrolment of patients.

Family medicine is attracting more recent medical school graduates, a trend likely affected by new physician payment models, increases in the number of primary care providers, and efforts to better integrate non-physician providers into clinical practice.

BOX 7.10 RECENT INNOVATIONS IN DUTCH HEALTH CARE REFORMS

- Introduction of private insurance based on the principles of primary care-led health care and including all citizens irrespective of their financial, employment, or health status
- Introduction of primary care collaboratives for out-of-hour services and chronic disease management
- Primary care team building, including practice nurses.

These innovations were introduced on top of a strong primary care tradition of family practices with defined populations based on patient panels, practice-based research, evidence-based medicine, large-scale computerization, and strong primary care health informatics.

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Since 1948 health care in the United Kingdom has been centrally funded through the National Health Service which provides both primary and specialist healthcare which is largely free at the point of delivery. Family practitioners are responsible for registered populations of patients and typically work in groups of four to six self-employed physicians. They hire nurses and a range of other ancillary staff, and act as gatekeepers to specialist care. Recent reforms include a wide range of national quality improvement initiatives and a pay for performance scheme that now accounts for around 25% of family practitioner incomes.

7.2 ESTABLISHING PROFESSIONAL ORGANIZATIONS FOR FAMILY DOCTORS

In most countries where family medicine has developed, a professional organization has been established by family doctors for family doctors. This section explores how professional organizations are established and why they are important for the development of family medicine.

WHAT KIND OF PROFESSIONAL ORGANIZATION?

Professional organizations of family doctors are called by different names in different countries and may serve different functions. They may be known as societies, associations, colleges, or academies. What matters is not the name, but the function performed by the organization. There are many different sorts of family medicine organizations and they may serve different functions within a country, for example political roles such as unionizing and networking.

Colleges should be standard setting, with accreditation to Fellowship through assessment, and providing reaccreditation in line with colleges of other medical specialties. Without this, family medicine cannot be viewed as a specialty alongside other medical specialties. Usually the accrediting college needs to be recognised by the medical council of that country.

National or regional organizations of family doctors often begin as a means of networking, organizing and facilitating communication among family doctors in a geographic area. Some countries organize all of their functions under one unifying organization. Others have several organizations that may serve distinct and complementary functions. For example, in the United Kingdom, the political, certifying, and academic functions are all roles of the Royal College of General Practitioners. In contrast, the United States has several organizations, including the

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American Academy of Family Physicians, the American Board of Family Practice, and the Society of Teachers of Family Medicine, each with defined roles.

WHY ESTABLISH A PROFESSIONAL ORGANIZATION?

Organizations of family medicine exist to raise the standards of care for patients and communities. This is their unifying theme and their greatest success has been when responsibility to patients and to the community has been their paramount concern. For example, the mission of the Royal College of General Practitioners is “to encourage, foster and maintain the highest possible standards of general medical practice.”

Another important goal of a professional organization is to establish family medicine as an independent discipline of equal importance and standing to other specialist medical disciplines – in other words, as an independent academic discipline in its own right. This includes facilitating the development of academic departments and faculties of family medicine in medical schools and recognition by the nation’s medical specialty accreditation authority. The professional organization can play a central role in establishing positive relationships with politicians, health authorities, professional colleagues, medical schools, and the public. The professional association can also help provide the rationale and public support to obtain funding to establish academic departments in medical schools, faculty training programs, and model family practices in the community.

Family practice associations provide a rich array of expertise and resources to assist in the development of the specialty. They provide opportunities for family doctors to locate colleagues with shared interests and to collaborate on joint community and research projects. Family medicine networks at the local, regional, national, and international levels allow colleagues to develop specific aspects of the specialty, such as teaching, research, or quality improvement.

Another important activity of professional organizations is training new doctors in their chosen discipline and certifying that they are properly trained. Until national standards are established and widely disseminated, there will be confusion regarding the identity and skills of family doctors. National organizations can exert considerable influence on training programs by establishing minimum training requirements and core competencies for certification.

Professional family medicine associations may supervise the process of certification or certifying bodies may be organized independently. There are a variety of approaches to certification. These tend to fall into two categories: (1) meeting defined

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standards of professional performance in the setting of the family practice or (2) passing an examination. For example, the Royal New Zealand College of General Practitioners and the Royal Australian College of General Practitioners both provide options for candidates to qualify for specialty certification through clinical training and examinations or through practice eligibility routes.

In some countries, the standards for training and recertification of family doctors are more stringent than for some other medical specialties. The certification process for family doctors may include methods such as assessments of consultation and communication skills, practice management skills, ethical standards, patient satisfaction, and medical chart audits. In many countries, family doctors are required to complete a minimum number of hours of continuing medical education annually in order to maintain their certification. In the United States, the American Board of Family Practice was the first specialty society to require members to pass a recertification examination every 7 years.

Providing appropriate, continuing medical education for family doctors is another important service of national associations. This includes conducting educational programs as well as certifying that educational activities are well designed and appropriate for improving the skills of family doctors. The latter function is important because inappropriate educational activities may be intended to persuade family doctors to use specific products or unnecessarily refer patients to other sources of care.

WHEN SHOULD A PROFESSIONAL ORGANIZATION BE ESTABLISHED?

Forming an organization for family medicine depends on the development of a critical mass of enthusiastic family doctors. When family doctors are able to work together, share common goals, and have a clear idea that family medicine is an internationally recognized discipline that can play an important role in their country, they are often ready to form effective organizations.

It is not necessary to have large numbers of general practitioners to form an organization. The Royal College of General Practitioners, for example, was formed in 1952 by a steering committee of only 16 members. To be productive, however, there needs to be a body of subscribing members who can, through their subscriptions, finance a fledgling organization. This will usually mean at least a few hundred members. The Royal College of General Practitioners got off to a good start when Foundation Membership was offered to established general practitioners who satisfied defined criteria, with 1655 doctors joining in the first 6 weeks.

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It is not necessary for all who are eligible to become members. Some organizations have nearly all eligible doctors in their countries as subscribing members, while others may have only one third to one half of all eligible doctors as members. This also depends on the type of organization; for example, in a college accrediting to Fellowship status and also offering reaccreditation, it may be necessary for all full members to be qualified family medicine specialists.

WHO CAN BECOME A MEMBER OF A FAMILY MEDICINE ORGANIZATION?

A major question is who should be the members and who should be the leaders of a family medicine organization. Such organizations are more likely to have an impact on family practice when they include and represent practicing family doctors in the country concerned.

A matter that frequently arises in the early phase of forming an organization is that of the qualifying credentials for membership. Most new colleges, associations or societies start by accepting any family doctor who is prepared to make a commitment and pay the initial subscription. As the specialty matures, more rigorous standards are often introduced and membership may be restricted to certified or recognized family doctors.

As primary care becomes increasingly multi-professional, some colleges and associations of family doctors may accept primary care nurses and other primary care health professionals as members. One of the first organizations to do this is in Hungary. The Society of Teachers of Family Medicine in the United States accepts any teacher of family medicine, including nurses, psychologists, and anthropologists.

HOW TO FORM A FAMILY MEDICINE ORGANIZATION

How do family medicine organizations get started? The leadership of general practice organizations has to be drawn from family doctors themselves, both to demonstrate professional independence and also to create a cadre of family medicine leaders who may serve as role models. Typically, the leadership of family medicine organizations is assumed by charismatic, service-oriented family doctors with a clear vision and a strong sense of purpose. Such individuals usually have the ability to make things happen locally and a track record of success. They may or may not have established academic careers. The core characteristics of leadership in professional bodies are vision, the ability to speak and write well, good organizational skills, and dedication to the cause.

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In some countries, the emerging professional organization may require the involvement or assistance of the government. The nation's chief doctor or minister of health may be particularly helpful. Every organization will operate within the culture and political system of its country, but it is desirable in the long term for these organizations to become fully independent of government. An example of the establishment of the College of Family Physicians in Poland and how this development has strengthened and enhanced family medicine and health care in that country is in **Box 7.11**.

One question to consider is whether or not the emerging family medicine organization should be an independent body or should begin as a branch of a specialist organization. Each choice has advantages and disadvantages. Becoming a branch of a well-established specialist organization has the advantage of an easier beginning, and immediate access to staff such as managers, public relations officers, and finance officers. It often means avoiding costs, such as those arising from setting up headquarters in an expensive building in a capital city. However, sometimes such organizations have not felt as independent as they would wish.

On the other hand, starting a new organization means a lot of work: setting up new systems for everything, usually renting premises, later fundraising to buy premises, and challenges in funding traveling expenses and staff, particularly in the early years. However, the advantages are self-government, real independence, and, in the long term, the likelihood of greater influence.

WHERE SHOULD A PROFESSIONAL ORGANIZATION BE BASED?

Professional organizations are mostly based and work within an individual country.

In smaller countries, it can be valuable to combine resources and have a college that spans more than one country – for example, the Caribbean College of Family Physicians (www.caribgp.org).

Most family medicine organizations have found it necessary to set up an office in the capital city of the country concerned. This is because political power tends to be located in the capital, and access to government ministers, civil servants, and leaders of other specialty groups provides an opportunity to influence policy.

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BOX 7.11 ENHANCEMENT OF FAMILY MEDICINE AND HEALTH CARE IN POLAND

A family doctor task force was established in Poland in 1991, with the aim of enhancing family medicine to improve the quality and efficiency of primary care. The group, which was based in the School of Public Health in Cracow, but working for the Ministry of Health, reviewed the job descriptions and responsibilities of family doctors in other countries and prepared a draft document on the responsibility of Polish family physicians. The draft was made available for review by the public, and a final version was presented to the national College of Family Physicians and the Ministry of Health for approval. The document defines areas of competence of a family practitioner in relation to prevention, diagnosis, treatment, and rehabilitation, separating the responsibilities of a family physician from those of other specialists. The document constitutes the official basis for family medicine and for determining the scope of educational programs.

The College of Family Physicians was established in Poland in 1992 by 34 people, including members of parliament, health care administrators, academics, community leaders and practicing doctors. According to its statutes, the College accepts as new members only physicians holding a diploma in family medicine. A strategic plan was developed to establish family medicine departments and residency training programs, and to enhance the practice of family medicine.

Success built during the first few years led to further enhancements in family medicine. The first educational journal for Polish family physicians, *Lekarz Rodzinny*, was started in 1996 as a tool for continuous medical education and a forum for discussion and exchange of experiences. The journal is published monthly, has over 6000 subscribers and is widely read by family doctors.

Today, over 5000 physicians hold a diploma in family medicine and over 25% of Polish inhabitants are served by family physicians. Over 80% of trained family physicians are members of the College of Family Physicians – an organization that plays a leading role in the implementation of family medicine and in health system reform.

The European Union provided US\$14 million to support the establishment of nine university departments as regional training units for family physicians, as well as to provide initial training of consultative family medicine teaching staff in Western Europe. Three additional departments and 600 practices were financed by a

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World Bank loan. Modern family practices started work at the end of 1995 and by the end of the first year it was clear that they were more effective and efficient than the old model. Studies showed that they enjoyed a high level of acceptance by patients.

Family medicine was recognized as an independent medical specialty in Poland in 1996, not only by the government but also by the autonomous university, which established family medicine as a subject taught during basic medical education.

7.3 FINANCING PRIMARY HEALTH CARE SERVICES AND FAMILY DOCTORS

It can be assumed that implementation of government health policies and health initiatives will only succeed when health systems are rationally funded to achieve priority objectives. A priority goal of primary health care is to provide easy access to essential health services for all, with as few financial barriers as possible. A number of physician payment options may exist in any country or health care system. Payment options include fee for service, salaries, capitation payments, integrated capitation, and combination payment systems. While the advantages and disadvantages of each option may vary depending on considerations particular to a given country, some generalizations about the main systems of payment can be made.

FEE-FOR-SERVICE

In fee-for-service systems doctors are paid an amount of money for each service or activity they provide. Fee-for-service systems are organized around fee schedules that classify physicians' activities with varying degrees of precision. Using this system, medical practice can be influenced by selectively adjusting the fee schedule so physicians are only paid or paid relatively more for services considered to be effective. For example, payments for screening procedures or preventive services can be increased to stimulate these services. Fee-for-service payment allows physicians to respond in a flexible manner to patients' perceived needs and connects financial payment directly with these activities. Some health systems that principally use fee-for-service payment have experienced spiraling costs resulting from the unrestrained incentive to pay for any service provided.

A recent study has found that newly practicing physicians in British Columbia, Canada, prefer alternatives to fee-for-service payment models. These models are perceived as contributing to fewer frustrations with billing systems, improved quality of work life, and better quality of patient care.

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In health systems financed by fee-for-service payments, patients may or may not be registered with specific primary care doctors. In addition, fee-for-service payments may be associated with relatively higher payments for diagnostic studies and medical procedures, but relatively lower reimbursement for “cognitive” services, such as counseling and education, which are usually a feature of the practices of family doctors. As a consequence, the financing system may not reinforce the functions of the family doctor to provide continuous, coordinated, and comprehensive care.

Despite several shortcomings, fee-for-service is still considered and retained as a remuneration model for many physician services.

SALARY

A salary system pays doctors a contractually agreed sum of money for a specified amount of time worked or patients treated. Salaried family doctors are able to combine many primary care roles with other administrative and public health duties. Patients may or may not be registered with individual family doctors. If the level of remuneration is relatively low, morale may be adversely affected. Furthermore, in a fixed salary system, family doctors do not receive additional payment for exceeding the required patient load. This can undermine the efficiency and functioning of the system, particularly if the physician has the capacity to earn more in the private sector.

CAPITATION PAYMENTS

In a capitation-based financing system the health care professional is paid a specific sum of money for providing continuous care for a person or group of people for a particular period, however much or little the service is used. For primary care, the system depends on patients being registered with a family doctor or group of family doctors that the patient is normally able to choose. The sum payable is usually fixed on a regular basis, often monthly and in advance of the period covered. This sum represents an estimate of how much it will cost to provide the patient’s entire health care needs over that time period.

There are several benefits of capitation payment systems for family doctors. This method of funding requires registration of patients with a specific family doctor or group. As a consequence, patient registries associated with capitation systems give family doctors a central role in caring for the patient’s common health problems and in coordinating secondary and tertiary care. Capitation systems provide a fixed budget

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for family doctors to hire staff and buy equipment, and eliminate the administrative burden of sending bills and tracking payments for each service provided. Capitation systems encourage the development of partnerships for financial risk sharing. In the United Kingdom, where capitation payments comprise the major component of family doctor incomes, very few family doctors work in solo practice. It is common for groups of doctors to organize after hours coverage for their patients by grouping together in cooperatives or working with commercial services.

Capitation payment systems pay family doctors a fixed payment whether or not they see the patient and no more if they provide more costly services. This can be a disincentive to family doctors who wish to expand their scope of practice. Few if any systems rely solely on capitation payments to pay family doctors.

In a study carried out on people with hypertension in Ontario, Canada, it was found there were differences in treatment and control rates, with capitation physicians having the best treatment and control rates in comparison with those on salary or fee-for-service model.

INTEGRATED CAPITATION

In an integrated capitation system, payments made for services delivered by different providers or at different levels of care are incorporated into a defined sum of money. Integrated capitation differs from simple capitation by incorporating payments to cover specific additional expenditures such as drugs, diagnostics and some areas of secondary health care. Hospital-based care may be included in an integrated capitation contract and provided by a larger group, such as the health maintenance organizations in the United States, or may be purchased directly by family doctors. Integrated capitation facilitates continuity of care, interdisciplinary coordination, preventive services, and care for patients with chronic diseases, while permitting cost containment.

In Belgium, a study by the Federal Knowledge Center on Health Care, revealed that compared to fee-for-service-financed practices, community health centers financed with integrated capitation were more accessible, especially for socially vulnerable groups of people. There were no indications for risk-selection. Moreover, in terms of quality, the performance of the family physicians in the capitated system was at least equal to the performance in the fee-for-service- system, and where differences appeared, the better quality was in the capitation system: better performance in prescription of antibiotics, better preventive services, more cost-effective drug prescription.

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Integrated capitation depends upon a list of patients registered with a family doctor. It exerts considerable pressure on family doctors to reduce patient access to costly investigations and referral to the secondary and tertiary care sectors. This system may favor the selection of patients with low health risks and the rejection of those with high risks. Continuity of care and interdisciplinary coordination may be enhanced because there are incentives provided to physicians for disease management beyond the boundaries of primary care.

COMBINATION PAYMENT SYSTEMS

Each health care payment system has some disadvantages, so more countries are using a mixture of payment systems (see **Box 7.12**). Composite systems frequently include a basic payment, usually capitation or salary, with additional incentive payments or allowances to encourage selected clinical activities. Target payments may be used as incentives to provide certain types of service, such as immunization, or more frequent visits for people with chronic conditions such as diabetes. Additional payments may be given to reward family doctors or family practices that provide extra services over and above the normal contract or outside the usual working hours, such as being open in the evenings and weekends, conducting health education groups or providing services for the disadvantaged.

BOX 7.12 BAMAKO INITIATIVE

In some communities, local people have assumed greater responsibility for health system guidance and financing. Through the Bamako Initiative launched in 1987, many African nations found that a combination of user fees and public funds could be used to improve the quality of primary care services. Follow-up revealed that, in some cases, the initiative generated additional funds, and increased quality and utilization of services, even among the very poor. However, for some groups, even minimal charges created obstacles and required further solutions to ensure equity. The 2010 World Health Report of the World Health Organization has recommended lowering out-of-pocket payments as the optimal way to ensure universal access to health care services.

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PAY-FOR-PERFORMANCE

In some countries, health care providers may be paid in relation to performance. In the United Kingdom, different domains of the Quality and Outcomes Framework have contributed to this payment system, and indicators have been created in order to assess the degree of clinician and practice “performance.” Evaluation has shown that the quality of care, for those conditions included in the program, improved during the first year at a faster rate than the pre-intervention trend and subsequently returned to prior rates of improvement. There were modest cost-effective reductions in mortality and hospital admissions in some domains. Differences in performance narrowed in deprived areas compared with non-deprived areas. Doctors and nurses believe that the person-centeredness of consultations and continuity of care were negatively affected by this system of payment. Patients’ satisfaction with continuity of care declined, with little change in other domains of patient experience. Observed improvements in quality of care for chronic diseases were modest. Health care organizations should remain cautious about the benefits of similar schemes.

FINDING THE BEST WAY

There is no ideal single method for remunerating family doctors to encourage the provision of every facet of continuing, high-quality primary care. The advantages and disadvantages of each method of payment were analyzed by a group of 57 delegates from 56 countries, who found that there was little valid literature available but concluded that a mixed payment system may be the most effective.

Family doctors may be best funded when they are supported as a component of comprehensive primary health care services, and through a combination of capitation or salaried payment plus targeted payments to encourage specific services. Equity is achieved when primary care systems are funded so that the entire population has ready access to services, with limited financial barriers for essential care. **Box 7.13** lists financing strategies that are likely to improve the quality and comprehensiveness of primary care services.

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BOX 7.13 FINANCING STRATEGIES TO IMPROVE PRIMARY HEALTH CARE SERVICES

- Provide sufficient funding to support a strong primary care infrastructure
- Minimize financial barriers for people to access essential health services
- Provide financial and other incentives to attract family doctors to areas of greatest need
- Use a combination of payment methods to support and reward high-quality, comprehensive, equitable primary care services
- Measure performance and provide incentives for targeted services such as preventive health care

7.4 IMPROVING ACCESS TO PRIMARY CARE

The goal of providing equitable health care for all has implications for health workforce policies and the recruitment and training of family doctors. In general, if health professionals are allowed to select their practice locations, they tend to choose environments with which they are familiar, where they have family or friends, or where there are good social, cultural, economic, and educational opportunities. Preparing and recruiting family doctors and other health professionals to provide care for the disadvantaged – those who lack access to essential health care services because of financial, geographical, ethnic, racial, or other barriers – presents special challenges.

Difficult working conditions including poverty, limited educational and employment opportunities, and high crime rates frequently characterize disadvantaged rural and urban communities. Because the disadvantaged are frequently poor, and poverty is a risk factor for poor health outcomes, the disadvantaged often suffer disproportionately from increased morbidity and premature mortality.

Much of the world's population lives in rural areas and people in rural and remote communities universally have poorer health than urban people. Often the health status of special needs groups, such as women or elderly or indigenous people, is worse in rural areas than in metropolitan areas. Despite this, rural health services command proportionately fewer resources and staff than urban health services in almost every country in the world. The worldwide shortage of rural health professionals results in those working in rural areas often becoming overworked and isolated, compounding the problems of recruitment and retention.

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Because family doctors are trained to provide comprehensive health care services and can work as coordinators and leaders in primary care, their presence ensures that a comprehensive array of health services is provided. In areas where other health professionals provide the majority of primary care, integrating family doctors into the teams will enhance the scope and quality of health services provided at the local level. Focused strategies and incentives are necessary to recruit family doctors and other health professionals to disadvantaged areas to attain the goal of universal access by all people to primary care.

RECRUITING FAMILY DOCTORS TO WORK IN DISADVANTAGED AREAS

Targeted recruitment programs may be necessary to identify and prepare the health care workforce needed for disadvantaged communities. Medical students who come from disadvantaged populations, or who have spent considerable time living and working in areas with such populations, are more likely to ultimately practice in these areas. Since areas with disadvantaged populations may not offer students the same educational opportunities, special programs may be required to attract youth from these areas to careers in the health professions, and to prepare them for the rigors of medical education. Another way of drawing health professionals toward practice in disadvantaged areas is to ensure that they spend time training in such areas. If students and trainees find these experiences stimulating and rewarding, they are more likely to consider such areas for their future practice, particularly when incentives are provided.

The Training in Health Equity Network (www.thenetcommunity.org) brings together medical schools that make a special effort to recruit medical students from remote and underserved areas, in order to better respond to the needs of those communities. This is an example of the increasing emphasis on the need for social accountability by those institutions responsible for the education of medical and other health professionals.

PROVIDING INCENTIVES OR REQUIREMENTS FOR WORK IN DISADVANTAGED AREAS

Financial incentives and educational or service requirements are common strategies to increase the numbers of health professionals in disadvantaged areas. In some countries service requirements are imposed on the entire medical student population. Graduates who are required to complete a period of practice in disadvantaged areas, unless appropriately trained and adequately supported to

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function as generalist physicians, may deliver low-quality care and be likely to leave the area as soon as their term of compulsory service has ended.

One strategy to recruit family doctors to disadvantaged areas is to increase reimbursement rates or salaries for providing care in such communities. In countries where physicians have to borrow money to finance their training, loan repayment programs are often used to encourage practice in disadvantaged areas. Such loan repayments are often provided in proportion to the number of years the physician practices in an area of need. Once health professionals begin to practice in such areas they often find the work rewarding and are willing to make long-term commitments. Such financial strategies and educational or service requirements are most effective when integrated with overall systems of financing health care services for poor and vulnerable populations.

SUPPORTING FAMILY DOCTORS TO PRACTICE IN DISADVANTAGED AREAS

Family doctors who work with rural and remote populations often need additional skills to be able to manage patients with surgical or other life-threatening emergencies or to provide culturally sensitive care to special populations. They may require protocols for remote consultation with other specialist doctors, specific language or cultural training, or an understanding of the local particularities of team management. Efficient systems of continuing and remote medical education are especially important for health professionals who practice in relative isolation. When family doctors have the opportunity to gain and maintain special skills, and are exposed to the realities of practice among disadvantaged groups during their specialty training, they are better prepared to meet community health needs, more confident of their abilities, and more likely to remain in disadvantaged areas.

Associations and networks of health professionals practicing in disadvantaged areas provide additional support. When resources are available, air transport has the potential to reduce isolation and speed the transfer of emergency patients from rural areas. Modern communication tools such as the Internet and satellite-based telephones may be used to provide rapid consultation and reduce the isolation of rural health professionals anywhere in the world. Professional associations offer opportunities for education, networking, problem solving, recognition, and other important social benefits. **Box 7.14** lists some ways of attracting family doctors to work in disadvantaged areas.

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No single strategy is likely to be effective in addressing the health needs of disadvantaged groups of people. Multiple strategies involving the health system, financing, policy development, and educational programs can prepare, recruit, and support family doctors to provide optimal care in areas where high-quality primary care is so desperately needed.

A well-planned and evidence-based approach is the only way forward to ensure universal access to primary care for all populations. Access to people-centered care is essential and provision of health services through a well-defined health system with a prime focus on a primary care model delivered by trained family doctors is the single most appropriate step to achieve health for all.

BOX 7.14 HOW TO ENCOURAGE FAMILY DOCTORS TO WORK IN MEDICALLY DISADVANTAGED AREAS

- Promote health policy and financing mechanisms that support primary care and the equitable distribution of health resources
- Recruit and select health professional students from disadvantaged areas
- Ensure that medical training includes experience providing health care to members of disadvantaged populations
- Provide doctors with the skills needed to practice in disadvantaged areas
- Require all new graduates to undertake a period of service in disadvantaged areas
- Enhance infrastructure and support networks
- Provide financial and other incentives to encourage and support family doctors working in disadvantaged areas
- Work with local communities on strategies to enhance recruitment and retention of family doctors

7.5 SUPPORTING PRIMARY CARE RESEARCH

Research conducted in the context of primary care is broadly divided into five categories as listed in **Box 7.15**.

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BOX 7.15 PRIMARY CARE RESEARCH CATEGORIES

1. *Basic research*: to develop research methods in the discipline
2. *Clinical research*: to inform clinical practice
3. *Health services research*: to improve health service delivery
4. *Health systems research*: to improve health systems and policies
7. *Educational research*: to improve education for primary care clinicians

Consistent with the breadth of primary health care, related research encompasses a broad range of topics including producing evidence to guide the treatment of people with diseases, not just diseases in isolation.

Examples of research that can best be done in primary care settings include:

- epidemiology and natural history of common primary care problems
- effectiveness of diagnosis and treatment of health problems in primary care
- methods to improve the process of primary care, including team development
- methods to improve the integration of community primary care with secondary and tertiary care
- the relevance of evidence-based medicine and treatment guidelines for patients seen in primary care with multiple problems or for people seen in different care settings
- methods to integrate preventive services with ongoing illness-oriented care
- reduction in errors and increase in patient safety in primary care
- determinants of patient and doctor satisfaction in primary care
- methods to improve education and research in primary care settings.

There is a particular need for effectiveness research – a continuing assessment of how one can, or when one should, translate health care research results into practice. There is also a need for research that defines the process and activities of primary care practice, to help understand how to better apply clinical knowledge from other settings to community practice, to guide future research about patient care, and to inform policy makers and educators.

Five decades ago, most medical research was conducted in hospitals or academic medical centers and with a reductionist, biomedical model to make technical advances to patient care. This has changed in the last 2 decades and a substantial

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amount of primary care research is being conducted in primary care settings. It is important to ask research questions in a variety of settings outside the hospital, as populations, disease patterns, and care systems differ, not only between countries but also in various regions of the same country. The focus on biomedical research and its application in hospital settings leaves many questions of importance to family medicine and wider primary care unasked and unanswered, and deprives the discipline of the robust research needed to improve practice and gain academic credibility. A new domain for challenge in research for family medicine and primary health care is the approach to multimorbidity, and the question how to make a paradigm-shift from “problem-oriented” to “goal-oriented” care.

Many important research questions can only be answered by physicians in community practice settings. For example, a study of an intervention for alcohol abuse showed that brief advice by the primary physician is effective in reducing the rate of problem drinking for up to 1 year following the intervention. Another study showed the effectiveness of aspirin and the lack of effectiveness of vitamin E for reducing coronary morbidity in people seen in primary care practices.

To increase the relevance of research to community-based practice, family doctors need to be involved in defining goals, questions, and methods of this research. For example, much of the interest in the problem of medical errors has focused on errors that occur in hospitals. This problem needs to be addressed in community practice as well, with the collaboration of community physicians.

An important benefit of primary care research is that it provides a venue for collaboration with specialists in other areas. Such collaboration enhances the intellectual richness of family medicine in both clinical and research areas. This in turn promotes family medicine as part of the academic and clinical mainstream. Being part of the mainstream is essential to the recruitment of excellent research students and academic staff members. Finally, and perhaps most important, research activities help to establish a scholarly role and a critical thinking mind set among family doctors that can lead to improvements in their quality of practice.

CHALLENGES FOR RESEARCH IN FAMILY MEDICINE

Research in family medicine draws on the strengths of a variety of available patient populations, problems, and practice settings that can serve as natural laboratories. Yet the lack of experienced researchers in family practice limits the amount, scope, and quality of research that can be conducted. Family doctors and other health

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professionals with interest and expertise in primary care are often underrepresented on grant development and grant review panels, which is likely to restrict the quantity and quality of projects in primary care research. Similarly, family doctors find it difficult to invest the time and money required to apply successfully for research project funding. As a result, despite recognition of the need for primary care research, government and philanthropic funding remains insufficient, especially for needed infrastructure such as equipment and research staff.

STRATEGIES TO ENHANCE RESEARCH IN FAMILY MEDICINE

Building a robust research enterprise comparable with that of other medical specialties requires contributions from busy individual family doctors. It also requires reallocation of funds, time, and resources within academic institutions, and support from national and other funding agencies to ensure that a significant portion of each nation's health and medical research focuses on the health problems most of the people have most of the time.

A renewed commitment to the role of research will be necessary in many countries, even those with well-developed academic family medicine departments and active professional societies. To achieve this goal, family doctors and their academic organizations may need to move on several fronts simultaneously.

It will be necessary for family physicians in community and academic settings to devote significant time and effort to designing and conducting worthwhile research projects, and writing applications to obtain funding. When successful with grant applications, family medicine researchers are then likely to be invited to participate in grant review panels and thereby begin to change the reductionist mindset typical of such panels. The research efforts of family doctors and group practices can also be enhanced through support, incentives, and grants from academic and practice organizations.

Individual family doctors, academic departments, and professional societies can work to raise the awareness among governmental and philanthropic donor agencies of the importance of funding primary care research. Most donor agencies are likely to support research for specific diseases, and individual bequests are usually made to foundations that fund research on a specific disease or group of diseases, such as cancer, rather than to support research on the comprehensive care that sustained the patient over many years. Agencies and benefactors need to be convinced of the importance of funding basic infrastructure for primary care research as well as for research into specific diseases.

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In order to mature as a specialty, family medicine needs experienced researchers. In many countries leaders of the new discipline lack formal research training or skills, are busy establishing vocational training and medical student programs, and deal with a host of educational, political, administrative, and funding matters that preclude an emphasis on research. Most academic departments of family medicine, however, have at best a very small number of experienced researchers. A growing number of family medicine organizations are starting to provide primary care research training programs. Some university departments of family medicine are making efforts to involve students in research activities and to encourage them to enter the discipline.

One solution to the lack of available mentorship is to establish close working relations with skilled researchers in other disciplines who can mentor new family physician researchers. Beyond mentorship, there are other reasons for collaborating with researchers in different fields of study, including other medical specialties, nursing, pharmacology, engineering, and anthropology, to name a few. The dialogue between disciplines provides the family physician researcher with expertise in different topics and methodologies, while helping other researchers understand the importance of primary care. This collaboration can also help family doctors learn how to tailor their funding applications to the interests of funding agencies. It is also possible to receive funding for participation in research projects originating in other fields.

Clinical family medicine and primary care networks provide an important means of supporting practice-based research. Effective networks can increase the productivity of research efforts. Practice-based research networks can stimulate research interest among community-based clinicians and make possible the participation of family doctors in all phases of project development and execution.

They can serve as a focal point for research activities by sponsoring meetings and workshops, and form a bridge between academic institutions and the community. Virtually all successful networks are partnerships between academic institutions and groups of community-based physicians. They are often housed in academic institutions and include an academic family doctor who is funded to provide time, support, and expertise.

Primary care research may be promoted through international collaboration. In many countries, organizations of family doctors face challenges of limited resources as they work to identify and address specific research needs. The potential for fruitful international collaboration, as primary care researchers share questions, methods, and new information for practice, continues to grow.

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BOX 7.16 HOW TO PROMOTE PRIMARY CARE RESEARCH (WORLD ORGANIZATION OF FAMILY DOCTORS KINGSTON CONFERENCE RECOMMENDATIONS)⁵⁷

1. World Organization of Family Doctors (WONCA) must develop a strategy to display research achievements in family medicine to policy makers, health (insurance) authorities and academic leaders.
2. WONCA should seek the development in all its member countries of sentinel practices to provide surveillance reports on illness and diseases that have the greatest impact on patients' health and wellness in the community.
3. WONCA should organize a clearinghouse for research expertise, training and mentoring.
4. WONCA should stimulate the development of national research institutes and university departments of Family Medicine with a research mission.
7. WONCA should organize an expert group to provide advice for the development of practice based research networks around the world.
6. WONCA should promote research journals, conferences and websites for the international dissemination of research findings.
7. WONCA should facilitate funding of international collaborative research.
8. WONCA should organize international ethical standards for international research cooperation and develop an international ethical review process.
9. WONCA should address in any recommendations for family medicine research the specific needs and implications for developing countries.

The World Organization of Family Doctors (WONCA) held a meeting in Kingston, Canada, of leading primary care researchers from across the globe. It came up with nine recommendations to promote primary care research (see [Box 7.16](#)).

Researchers may collaborate through groups such as WONCA, the North American Primary Care Research Group, and the European General Practice Research Network. Such groups of primary care researchers share ideas, and organizational and methodological expertise, to sustain and encourage one another in uniting practice and research to improve patient care (see [Box 7.17](#)).

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BOX 7.17 WAYS TO PROMOTE PRIMARY CARE RESEARCH

- Promote commitment to primary care research among:
 - family doctors
 - professional societies
 - academic institutions
 - government
 - philanthropic agencies
 - the public
- Develop research projects
- Improve research methodologies
- Train more primary care researchers
- Solicit a larger base of donors and other funders for primary care research projects
- Develop and participate in primary care research networks

7.6 ENHANCING QUALITY OF CARE AND OUTCOMES

There are wide variations in medical practice patterns and outcomes both within and between countries, and many opportunities to improve the quality, efficiency, and effectiveness of health care delivery. If family medicine is to fulfill its potential to meet the needs of patients and communities, delivering the highest possible quality of care is of critical importance. The complexity and scope of family practice, as well as its interface with many other aspects of the health system, make this goal particularly challenging.

GOALS AND DEFINITIONS

Quality in health care encompasses many complex and interrelated characteristics (see [Table 7.2](#)). It may also be viewed from a variety of perspectives. Patients, health care professionals, researchers, educators, public health officials, health system funding agencies, politicians, and others may each legitimately consider different aspects of health care as the most important. Ultimately, it is the totality of a health care experience that influences the patient's perception of quality. One negative incident, such as rude behavior from a staff member, may substantially diminish a person's perception of the quality of the entire experience.

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Quality in health care may apply to the structure, process, or outcomes of care. Structure includes personnel, facilities, equipment, organization, and coverage arrangements. Process includes activities involved in providing or receiving care, and attributes such as timeliness and continuity. Outcomes may include morbidity and mortality data, as well as quality of life and patient satisfaction.

Table 7.2 Dimensions of quality in health care

Dimensions	Characteristics
Equity	Services are provided to all who require them
Accessibility	Ready access to services is ensured
Acceptability	Care meets the expectations of those who use the services
Appropriateness	Required care is provided; unnecessary or harmful care is avoided
Comprehensiveness	Care provision covers all aspects of disease management from prevention to rehabilitation; psychosocial aspects of care are considered
Effectiveness/Efficiency	Care produces positive change in the health status or quality of life of the patient; high-quality care is provided at the provided at the lowest possible cost
Safety	Avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered

Achieving high-quality health care is not a one-time effort; it requires continuous attention. Responding to new information and developments in medicine means ceaseless efforts to ensure that family doctors deliver high-quality services based on the best current evidence for practice. The WONCA Working Party on Quality in Family Medicine (**Box 7.18**) defines high-quality health care as: “the best health outcomes that are possible, given available resources, and that are consistent with patient values and preferences.”

PROFESSIONAL PERSPECTIVES OF QUALITY

For health care professionals, quality of care has often focused on providing competent, effective and safe care that contributes to health and well-being. Clinical performance can be assessed by measuring the extent to which the services delivered are consistent with the current state of knowledge and provided in a timely manner.

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BOX 7.18 MISSION OF THE WORLD ORGANIZATION OF FAMILY DOCTORS WORKING PARTY ON QUALITY IN FAMILY MEDICINE

The mission of the World Organization of Family Doctors Working Party on Quality in Family Medicine is to support family doctors around the world in their efforts to review systematically and improve continuously the quality of health care they provide.

This mission is based on the following principles.

- To improve the quality of care, family doctors strive for the best structure, process, and outcomes of health care consistent with patient values and preferences, consistent with professional knowledge of appropriate and effective care, and given available resources.
- Quality efforts should promote accountability, and reflect a partnership between patients and health care professionals.
- Quality efforts should be explicit, systematic, a routine of daily practice, an integral aspect of basic and continuing medical education, consistent with the special role and setting of the family doctor, and applied in a positive, not punitive, manner.

One approach is to measure quality against standards for good practice. Evidence-based practice guidelines, usually developed through a process of group consensus, compile findings from multiple sources and outline the best recommendations for managing frequently occurring problems. Their usefulness is enhanced by flexibility (enabling them to be modified according to local circumstances), conciseness, reminder systems, and educational activities that support implementation.

Family doctors also recognize and value the humanistic and qualitative aspects of patient care, such as establishing therapeutic relationships, providing respect and empathy, addressing patient fears and sharing decision-making with patients and families. Health system managers and funders often emphasize such important aspects of quality as efficiency, logistics, available supplies, accurate record keeping, and cost-effectiveness. Public health officials often focus on measurable indicators and outcomes, such as achieving specific immunization rates or reducing age-specific mortality rates. Academics and health system managers view educational scholarship and research as tools to assess and improve quality.

Traditional quality indicators commonly address the accuracy of the diagnostic process and the appropriateness of the therapy for particular diagnoses. Although

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these are critical considerations, they provide an incomplete reflection of the complexity, richness, and depth of patient-doctor interactions. Thus efforts have been made to supplement conventional indicators with approaches more focused on patients' problems, their functional health status, their ability to perform activities of daily living and their health-related quality of life, including estimates of the years they would be expected to live in good health. These indicators improve capacity to assess the overall health of a population, judge the efficacy of interventions, and make comparisons across populations.

PATIENT SATISFACTION

People often evaluate quality based on whether their expectations are met in their interactions with health professionals. Patient expectation and patient satisfaction surveys are very useful tools to monitor and improve quality in family practice.

Patient satisfaction may be measured and regularly reassessed, such as the time a patient spends waiting for a visit, the patient's confidence in the competence of the treating doctor and other members of the primary care team, the patient's perception of being understood and respected, and the patient's assessment of their doctor's communication skills and the friendliness and helpfulness of the office staff. Several patient survey tools are available and offer the means to incorporate into clinical practice the opportunity to monitor and improve patient satisfaction (aafp.mydocsurvey.com).

ASSESSMENT OF QUALITY IN HEALTH SYSTEMS

Health care quality may be influenced at many levels and by many components of the health care system. At the level of the individual health care professional, quality is determined by interactions between the patient and doctor. At the level of the practice, quality is affected by the patient's interactions with their family doctor, receptionists, clinical staff, nurses, and ancillary services. At the local level, groups of doctors, clusters of practices, and the availability of resources and facilities will have an impact on quality. At regional and national levels, health care policies, financing, allocation of resources, information gathering, and standards of education and certification can influence quality and structures of care throughout the health system. Information derived from each level of the health system may be used to assess different aspects of quality (see [Table 7.3](#)).

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Table 7.3 Sources of data to assess quality of health care

Level of care	Examples of data sources
Individual family doctor	Patient satisfaction surveys Medical record reviews
Family practices and other community-based health centers	Aggregate patient satisfaction surveys Group record audits
Local health system	Hospital records Pharmacy data Local public health data (e.g., birth and death certificates) Financial data
Regional or national	Morbidity/mortality rates across health system Expenditures

PLANNING TO IMPROVE THE QUALITY OF FAMILY MEDICINE

Given the broad scope of family practice, growing expectations for health care, limited resources, and rapid developments in medical information, achieving the best quality presents special challenges for family doctors. Additionally, as family doctors often work in health care teams, systematic team efforts are necessary to improve the quality of care.

Each level of the health system provides opportunities to enhance the quality of care. At the level of the individual family doctor, their abilities, interests, training, certification, and participation in continuing education influence competency and quality. While each physician is responsible for maintaining professional skills and knowing her or his own limitations, requirements for professional certification and incentives for quality performance will influence the physician's motivation.

At the practice level, quality can be enhanced when teams work collectively toward shared goals. In these settings, small practice groups or clinical networks may select specific areas for quality improvement, such as increasing immunization rates or improving blood pressure control. Increasingly, doctors and other health professionals pool their efforts to develop formal or informal practice networks, to critically examine current medical studies, and to develop evidence-based guidelines for high-quality care.

At the national level, government or professional associations can require regular review and certification of doctors and their practices. These standards often include requirements for training, examination, continuing education, and practice audits. Many countries have found that investments to improve quality result in better health outcomes, reduce costs, and enhance effectiveness.

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Quality improvement efforts also occur at an international level. The European working party on Quality in Family Practice (Equip) includes more than 30 countries that meet regularly to undertake collaborative quality improvement projects. Such groups work together to develop international guidelines and standards for performance. However, universal guidelines require adaptation and consideration of resources and cultural factors for successful implementation at the local level.

THE PROCESS OF QUALITY IMPROVEMENT

Improving the quality of health care, regardless of the level of care, involves teams of individuals who collaborate to achieve shared goals. The planning process usually begins with an analysis of the current situation. For example, a small group may meet to analyze and identify the group's strengths, weaknesses, opportunities, and threats (SWOT). A SWOT analysis or similar procedure allows the group to identify and celebrate strengths, and to consider any identified weaknesses as opportunities for future growth and development.

After considering the potential opportunities, the group may then select a priority for quality improvement. This allows the group to focus their efforts, consider needs for funding and other resources, and anticipate potential problems. Selecting a specific problem that is feasible given available resources increases the chances of success. Involving key individuals who will participate in quality improvement efforts increases their motivation to participate in subsequent actions and analyses. Ideally, both those who will implement and those who will be affected by the changes should be consulted to obtain their advice and commitment to participate, and to establish realistic goals.

Many potential areas for improvement exist in a typical family practice, but they cannot all be dealt with at once. It is more effective to start by selecting one important problem area for improvement, collecting baseline information, implementing changes, and evaluating the impact. After completing an initial, successful quality improvement project, the practice team is usually enthusiastic about participating in subsequent projects.

Often, groups find the stepwise quality cycle a useful framework for improvement efforts. Many possible variations to this cycle exist, and the steps need not be completed in the order listed in **Box 7.19**.

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TEACHING TO IMPROVE QUALITY

While most health professionals understand the importance of quality improvement in health care, many are less knowledgeable about how to initiate and manage systematic quality improvement.

BOX 7.19 HOW TO IMPROVE HEALTH CARE QUALITY

- Select a topic or problem for quality improvement
- Form a team to address the topic
- Collect baseline data
- Reflect on current practices
- Plan changes
- Change work processes
- Collect data to assess the impact of changes
- Reflect on results
- Adjust process further if needed
- Measure again the impact of changes

Quality improvement skills may be introduced early in the medical school curriculum, further developed through vocational training, and enhanced through lifelong, continuing medical education. Education can provide trainees with the attitudes, knowledge, and skills to critically evaluate medical literature and to participate in research to generate knowledge when the literature cannot provide answers. When integrated into the continuum of family medicine education, skills for quality improvement may be developed at all levels of training.

Students can be introduced to quality improvement concepts and tools in medical school. The curriculum should include an introduction to the various aspects of quality, methods for measurement, and the steps necessary to complete the project. Problem-based learning techniques may be used to engage small groups of students in the development of a quality improvement project. Case reviews will allow students to understand the processes and potential pitfalls associated with improvement efforts. Small groups of students can be given the task of assessing aspects of quality and completing projects.

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Specialty training provides opportunities to infuse trainees with the attitudes, knowledge, and skills for lifelong quality improvement. The curriculum can introduce trainees to the fundamentals of quality, while clinical experience will provide ample material for projects. Although the fundamentals of quality improvement can be introduced in classroom settings, the application of knowledge and skills to clinical problems allows trainees to experience the complexity and satisfaction of a real project and is likely to instill confidence and enthusiasm for participation in future quality improvement efforts (see **Box 7.20**). Not all quality improvement projects are successful, and teams sometimes become disheartened. Guidance from experienced mentors can steer early learners toward projects that are more likely to result in substantial quality improvement.

BOX 7.20 FAMILY MEDICINE TRAINEES IMPROVING QUALITY OF CARE IN SOUTH AFRICA

Medunsa University in South Africa provides opportunities for physicians in government clinics and hospitals or private practice to complete family medicine specialty training through distance learning. Participants complete 12 learning tasks related to their clinical practice, a master's dissertation, and a final examination. One of the learning tasks is to complete a quality improvement project. Trainees are expected to find and weigh clinical evidence, to measure, analyze, reflect, and change a specific practice.

Through one such project, a trainee and his local health team identified a problem of high mortality rates during weekend and night shifts in a rural community hospital. By developing new on-call and reporting arrangements, mortality was reduced by nearly 20% over a period of 4 months. The trainee not only learned important lessons about quality improvement but also contributed to improvements in patient care.

CONTINUING MEDICAL EDUCATION

While quality training may begin in medical school and be further developed during specialty training in family medicine, ongoing professional training and support allow family doctors to maintain high-quality care throughout a lifetime of practice. Continuing education is most useful to practicing physicians when it employs the principles of adult self-directed learning, is based on experience and related to current practice, and allows opportunities for discussion and reflection among supportive groups of colleagues.

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As many practicing physicians have not received formal training in quality improvement, an understanding of the concepts and skills is also important. These physicians will benefit from targeted instruction that addresses the following knowledge and skills:

- dimensions of quality in health care
- the process of quality improvement and how to select and complete a project
- how to select target groups that will benefit from the quality improvement activity
- assessing the process, structures, and outcomes of family medicine and its relationship to the health and social systems
- assessing the costs, benefits, and effectiveness of quality improvement methods
- understanding variations of performance in processes and systems
- understanding how to develop new, locally useful knowledge through research.

When family doctors learn to apply these skills in their practices, and receive feedback and support from colleagues, they are able to lead and participate in ongoing quality initiatives in a variety of clinical settings.

HOW TO ASSIST FAMILY DOCTORS TO IMPROVE QUALITY

While teaching the principles and processes of quality improvements are important, knowledge and skills are not sufficient to assure that quality efforts are routinely included in family practice. Resources, incentives, and support systems can assist efforts to make the achievement of high-quality patient care a priority in family medicine. Some useful strategies are listed in **Box 7.21**.

BOX 7.21 STRATEGIES TO SUPPORT QUALITY IMPROVEMENT EFFORTS

- Engage leaders, stakeholders, and participants in understanding and supporting quality-improvement efforts
- Gain commitment to quality at local, regional, and national levels
- Allocate financial and human resources to quality improvement as a routine part of clinical services
- Provide incentives to assess and improve quality
- Consider the social, economic, and cultural context to select realistic priorities
- Establish standards and enforce regulations to identify and improve substandard services

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- Consider certification, recertification, or accreditation to ensure that family doctors develop and maintain appropriate skills
- Establish or join quality improvement networks

This brief introduction is provided as a starting point for those interested in improving the quality of health care through family medicine. A number of international and national organizations, many as members of WONCA, are networking to establish consortia to share findings and strategies. In particular, the resources *Family Doctors' Journey to Quality* and *Tools and Methods for Quality Improvement* compiled by EquiP provide many instruments that may be adapted for local use.

Continuing efforts to improve the quality of family medicine will enhance the effectiveness of family doctors in improving the health of their patients and their communities.

7.7 MOVING AHEAD

Family medicine is most likely to improve health system performance when based on careful consideration of local conditions. Countries in political transition face challenges as they attempt to forge a consensus in the direction that health care should take. Countries with large financial debts may have insufficient resources to make needed changes. Countries attempting to reform their health systems may face challenges in mobilizing groups of private practitioners toward supporting the broader societal goals of equity and access to essential services for the poor and other vulnerable groups of people. Family medicine will evolve differently in these different environments.

The future roles of family doctors should be considered in the wider context of health system improvements. Family doctors' contributions will be enhanced when they are integrated into effective primary health care delivery systems. Therefore, planning for the development or expansion of family medicine includes developing a vision, collaborating with key stakeholders, determining short and long-term goals, and improving health service delivery. When planners agree that health systems should be established on the values of equity, quality, relevance, and cost-effectiveness, these values will guide program development.

Collaborative efforts among citizens, communities, health system leaders, health professionals, academics, and government authorities have considerable potential to create the conditions necessary for change, particularly when these groups establish

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sustainable partnerships. It is the implementation of collaborative, intersectoral programs at the local level that presents the greatest challenges and holds the greatest promise for meaningful improvements in health systems, primary health care, and family medicine. **Box 7.22** lists some of the essential elements to be considered in planning a family medicine program.

BOX 7.22 ELEMENTS OF FAMILY MEDICINE PROGRAM PLANNING

- Delineate the ideal profile and desired competencies of family doctors
- Enlist support from key stakeholders
- Determine plans for education, accreditation, and certification
- Develop specific training programs
- Determine short and long-term needs
- Collaborate with stakeholders including other health professionals
- Develop integrated practice models
- Establish budget and acquire financial resources
- Assess costs, benefits, and areas for improvement
- Describe career paths and professional opportunities for family doctors

This guidebook provides a compass, map, and directions to assist in the never ending journey toward improving health systems. Even when well planned, journeys are often full of unexpected twists and turns. A guidebook cannot prepare travelers for all conditions. Readers who continue the journey of improving health systems with family medicine are invited to share your ideas, feedback, progress reports, and updates with WONCA. Your contributions will be reviewed, compiled, and used to assist future travelers.

For family medicine to serve as the backbone of an equitable, high-quality, comprehensive, primary care delivery system, many complex and interrelated issues need to be considered. The evidence is clear that family medicine has the potential to assist health systems to provide comprehensive, high-quality, and affordable health care for all. The ability of family doctors to fulfil this potential will depend on the decisions, resources, and capacities of the health systems in which they will function.

This guidebook aims to provide health system decision makers with relevant knowledge and tools to facilitate the process of improving health systems to better meet the health care needs of all people in the world.