Commentary

The way we do things around here

Advancing an interprofessional care culture within primary care

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Last month, the Section of General and Family Practice of the Ontario Medical Association took out advertisements in major newspapers and magazines insinuating that Ontarians might put themselves at risk if they were to receive care from nurse practitioners and pharmacists.[1] I was shocked and dismayed at the message put forward—yet not surprised. Turf wars are not new. But in primary care they are getting ugly. In the name of the patient, advocates are coming forward to state their cases why they are in a better position to provide patient care. Fear mongering, however, is not a solution. As good clinicians we should be asking, "Where's the evidence?"

Strong evidence for interprofessional care

Barrett and Curran[2] found high-quality evidence supporting positive outcomes for patients, providers, and health systems when an interprofessional approach to the delivery of mental health care and chronic disease prevention and management in primary care settings was used. In this month's issue of *Canadian Family Physician* Hogg et al (**www.cfp.ca**) reveal statistically significant improvements in quality of care in their randomized controlled trial conducted with family physicians, nurse practitioners, and pharmacists who provided an intensive interprofessional approach to chronic disease management of at-risk populations.[3]

McKinnon and Jorgenson (**www.cfp.ca**) share improvements to the prescription renewal process in their practice, which enhance physician efficiency and patient safety.[4] Strong evidence continues to emerge suggesting that the use of interprofessional care methods in primary care improves patient care.

So what's the holdup?

The Institute for Healthcare Improvement shared a very interesting report that articulated some of the challenges faced in engaging physicians in a quality agenda.[5] The report recognized that physicians are acculturated to a strong belief system related to personal responsibility for quality of patient care and a strong need to practise with full individual autonomy:

> Physicians are taught that "if [they] work and study hard enough, [they] won't make a mistake." This leads them to believe that if a mistake does happen, then someone didn't work hard enough or study hard enough.[5]

As we move toward a collaborative model, the belief system of personal responsibility ingrained in physicians gets in the way of innovative approaches to care. How can we as family physicians trust other health care professionals working with us? How do we know that they will not do any harm to the patients with whom we have developed relationships over the years? As family physicians, we do not know how nurses, nurse practitioners, and pharmacists are educated. Certainly their education has not been guided by the same principles as ours has—or has it? Do other health care professionals have to maintain their competence through continuing professional development? It is much too easy to leave these questions unanswered. Yet by doing so, we fall back into a position of distrust, which we often use as a defense mechanism to avoid testing the waters of change.

Trust is not a necessary condition for collaboration, unless one perceives a risk[6]; however, as we move toward collaborative approaches in the primary care setting, trusting those who work with us becomes a critical issue. The literature[6,7] indicates that trust can be built if 3 factors are addressed: competence, receptivity, and shared values and principles.

Building trust

A colleague and I have conducted a workshop for the past 2 years at the annual Family Medicine Forum in Canada[8] during which we challenge participants to consider the definitions related to *roles, tasks, competence,* and *scope of practice* in order to explore enablers or barriers to team-based approaches to care. *Role* can be defined as a prescribed or expected behaviour associated with a particular position or status. The CanMEDS roles[9] and the CanMEDS–Family Medicine roles[10] define the expected behaviour of physicians (expert, collaborator, communicator, health advocate, manager, scholar, and professional) Yet these roles are not unique to physicians—they are used by occupational therapists, physiotherapists, and others.[11] The term *task* refers to an identifiable and essential part of a job. Examples include spirometry, smoking cessation counseling, annual health examinations, and prescription writing. In order for us to share tasks with other health care professionals, trust becomes important.

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As discussed earlier, competence is a key element for building trust. If pharmacists are going to be writing certain prescriptions for medications and nurse practitioners diagnosing certain conditions, then as health care professionals we need to trust that they are qualified to carry out these tasks. A health professional's scope of practice implies competence directly linked with the education and clinical experience received. Scope of practice and competence are often thought to be interchangeable. Scope is legislated by provincial governments and self-regulated by the professions, yet as family physicians we all know that although we might have the legislated scope of practice to deliver babies, we need to maintain our level of competence through continued practice and professional development to carry out this task in a safe and effective manner. It is important that all health care professionals who share tasks in a collaborative primary care delivery system understand what it takes to carry these tasks out competently. Competence can be taught and it can be measured. However, competence alone is not enough to build trust. Shared values and principles are also key.

Sharing the principles of family medicine

The 4 principles of family medicine[12] state that family physicians are skilled clinicians as well as resources for defined practice populations; family medicine is a community-based discipline that values the physician-patient relationship as one of its most central tenets. The 4 principles of family medicine can be applied, arguably, to any and all health care professionals who come to work in primary care settings. And if we do so, we can build a team of health care professionals who share similar values and principles and commitments to competence. By being explicit about our hopes and expectations for the type of care we want to provide in our family practice and primary care settings, we have a good chance of successfully creating a culture of care within which we can feel comfortable and confident practising.

Culture is an interesting term that continues to be bantered around in the literature related to advancing interprofessional care. According to Schein,[13] culture can be defined as the widely shared and deeply held values, beliefs, and assumptions of members within an organization. The culture of an organization can be seen in "artifacts," such as structures (eg, interprofessional committees), practices (eg, interprofessional care reviews and interprofessional hiring processes), and people's behaviour (eg, willingness to share tasks). The culture within an organization influences how people perceive, think, and act; how they speak; and how they make decisions. It influences members' patterns of thought and perceptions and the range of choices they see as rational or appropriate in a given situation. Culture is, simply, "the way we do things around here."

So let's promote an interprofessional way of doing things—a patient-focused, quality- and evidence-based interprofessional primary care culture—and help that culture to be adopted into our Canadian health care system, leveraging the principles of family medicine and advancing patient care outcomes.

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Competing interests
None declared

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