Masters of complexity

Celebrating the muddiness of family practice

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I had an "aha!" moment this year—one of those moments of sudden clarity regarding a perplexing challenge that has plagued you for years. I have often described what we do as family physicians as "muddy." It is hard to accurately capture in words the intricacies of managing patients over time—it is *muddy.* My moment came during a Canadian Institutes of Health Research conference on primary care. Brenda Zimmerman, a business professor from York University, was giving a seminar on complexity and health care.[1] The concept of complexity as she described it was a true "aha!" moment for me. She nailed it. She nailed what I was trying to describe using the term *muddy*. She introduced me to complexity theory and raised my understanding of family medicine to a new level.

Dr Zimmerman described 3 approaches to patient care: the simple, the complicated, and the complex. The simple is akin to a recipe—dealing with the "knowns." We *know* the problem. We *know* the solution. We see a patient. The patient has a laceration. The laceration is sutured. The laceration heals; simple and straightforward.

Then there is the complicated. We start with the unknown, work with our medical knowledge and skills, and go from the unknown to the known. We start with something like abdominal pain and do a history, a physical examination, and tests to come up with a diagnosis. We then apply an intervention and presumably achieve cure or control. This is the world of many of our specialist colleagues. They deal with the complicated, and their world involves going from the unknown to the known. This is the world of clinical practice guidelines and much of evidence-based medicine. Simplistically, it is the world of body-as-machine, where we find and fix the broken part.

Now move to the muddy world—the complex. Move to the world of family doctors and primary care. This is the world of the unknowable. How often do we see things we cannot pin a diagnosis on? How often is time our diagnostic friend, and whatever was going on eventually settles and is gone—resolved and forever undefined? Dr Zimmerman uses the analogy of raising a child. There is no one book, no recipe, and no magic bullets for dealing with the complex. There are too many permutations and different computations for us to control and understand. We do our best with what we know and are confident in our understanding that raising a child is complex and that success is mostly about relationships.

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Patient care in family practice is complex. Often clinical practice guidelines just do not fit because of the intricate, interwoven web of medical issues that makes sorting each out independently next to impossible. The context of patients' lives, and hence their illnesses, is also not to be treated as if it does not matter or contribute to their care and health outcomes. It all matters. It all influences what happens and what needs to happen.

Complexity theory has been in the medical literature for some time. I do not think it is being taught in medical schools, yet I have found nothing to better explain what we do as family physicians and the value we bring to the system. For years we have been relegated to the world of the simple and have been offered best practices that treat primary care as though it deals with, at worst, the complicated. For years we have struggled to explain to students and colleagues the muddy uncertainty and ambiguity we live with in general practice. Now we have complexity theory giving clarity to our world. This is not the world of body-as-machine, but one that appreciates patients' bodies as complex systems, patients' lives as complex lives in complex environments, and context as critical to care.

I think this is incredibly important as we try to ensure that governments, colleagues, faculties of medicine, and others understand what we do. We are generalists. We value relationships and continuity. We do not define ourselves by a body part or system but by relationships. We take all comers and manage all problems. There is no other health care provider that can substitute for the value we bring. We are the mangers of the complex.

We must embrace this role and preserve our focus on comprehensive care. Family physicians are those best trained to manage complexity. We do it well and we can learn to do it better. We need to advocate for the tools to improve and evaluate this important role.

I hope you will share in my "aha!" moment—transforming the muddiness to complexity—and celebrate both the skills needed to do this work and the fundamental value of the relationships we share with our patients. If we need to wallow from time to time, let it only be in the muddiness. Dealing with complexity is challenging work. We should be proud as a discipline. I am proud to be a master of complexity and I am especially proud to have served the College over the past year. Thank you.

Reference

1. Zimmerman BJ. *Primary care system and practice change: complex or (merely) complicated?* Paper presented at: CIHR Primary Healthcare Summit: Patient-Oriented Primary Healthcare—Scaling Up Innovation; January 18-19 2010; Toronto, ON.