Dangerous ideas

Top 4 proposals presented at Family Medicine Forum

The Dangerous Ideas Soapbox, a concept borrowed from the Society for Academic Primary Care in the United Kingdom, began as a new feature at Family Medicine Forum in 2013. The Dangerous Ideas session offers a platform for innovators to share important ideas with the family medicine community. A Dangerous Ideas Soapbox proposal presents an idea, its novelty, why it is dangerous (ie, what is the challenge?), and why it matters. Sessions are devoted to giving the audience the opportunity to challenge and critique the presenters, with a final vote to decide the most dangerous idea.

Here are the top 4 abstracts that were selected for the Dangerous Ideas Soapbox session held at Family Medicine Forum in November 2014 in Quebec city, Que. Following the finalists' presentations, audience members voted for which proposal they believed was the most compelling idea.

Fourth place: Harnessing the strength of social media in medicine

Health care professionals are avid users of social media and digital resources: 93% of University of Alberta medical students report current Facebook use; 60% of physicians exchange patient care–related photos and text messages; and 45% of physicians use their devices as medical references. A physician's professional and personal networks are assets to better patient care. There is currently no comprehensive framework in which these networks can be cultivated to improve care. I propose a model of care that encourages the use of communication tools like social media, in which clinical scenarios can be shared and discussed among medical professionals. Imagine the following scenario: You have just encountered a very interesting clinical case in a rural town. You share the case on your phone via a confidential network, and then you receive real-time comments and advice from physicians across the country. The archived case can be used in the future for teaching and research purposes. Of course, privacy concerns and incentives to participate are some important obstacles. However, it is very encouraging that this model is being developed and implemented right now in the private sector. For example, currently 125 000 health care professionals use an app called *Figure 1*, which allows health care professionals to share images, clinical encounters, and insights while safeguarding privacy. Similarly, there are companies like CrowdMed that introduce the concept of crowdsourcing to medicine. In a more national and comprehensive model with the appropriate incentives, quality and accessibility of primary care can be less dependent on geographic location or the size of a physician's network. Evidence-based medicine depends on the triad of best available evidence, patient preference, and clinical expertise. Social media in medicine allows for the dissemination

These abstracts have been peer reviewed.
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of clinical judgment and standardizes its delivery. In essence, it can be the "up-to-date" of clinical expertise.

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Third place: Full-time patient access to FPs' mobile phone numbers

All practising FPs should carry their cell phones 24/7 to take medical calls, except when they are out of Canada and the United States. This proposal is feasible, as most FPs carry mobile phones with them at all times, even on holidays, for personal use at least. It requires no new device or program to expand the use to taking calls from patients, their families, colleagues, laboratories, hospitals, etc. Current mobile phone coverage is very wide, from underground transit systems in cities to ski hills in rural areas. The advantage of this proposal is that it contributes to continuity of care, which has been shown to improve patient health outcomes. Being available 24/7 maintains continuity. As our patients' primary care physicians, we know their medical history and are best suited to providing medical advice in the context of the particular patient or representative calling. This can be enhanced by having electronic medical records with connectivity to our smartphones. Patients can be directed to the best source of care for the problems they are facing—whether it be to our on-call partners, a rapid access clinic, an emergency department, or a pharmacy. And our patients are delighted to have this contact. The problem with this proposal is that FPs need time off to recharge. I have been doing this for 3 years and I find the number of phone calls is low, as most patients are respectful of my time. It interferes very little in my active life. Those physicians who have not tried this approach are concerned that patients will abuse the privilege of having their phone numbers. When some patients start to call inappropriately, I warn them that their behaviour is not acceptable and inevitably they stop because they do not want to lose the privilege of access.

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Second place: What do your patients really think?

It was a busy day in clinic and I had just finished seeing Annie, a young woman with a sore throat. She was concerned about having pneumonia, and I explained to her why I believed she had pharyngitis and not anything more. Annie smiled, thanked me, and left. But had I really answered her questions? Had I reassured her adequately? This is when I realized that there was no formal system for my patients to give me feedback. Whether it was in the family doctor's office or in the emergency department, what did my patients really think about the care that I provided? When I explained things, did they really understand or were they just nodding their heads in agreement? In order to get a true sense of how the care that we provide is perceived by our patients, there needs to be a way in which patients can provide anonymous and confidential feedback to us. This method needs to be structured to address certain key areas, such as patient education, overall quality of care, and clarity of communication. Simultaneously, there needs to be a way to give open-ended feedback. There are things that might be important for the patient that are not perceived to be so by the physician. The idea is to give patients a confidential feedback card as a business card. It should have the physician's name, a website, and a password. Patients visit the website, enter the password, and fill out a form, giving their physicians anonymous feedback. This will give physicians a better understanding of how patients perceive the care they receive. It will allow us to identify areas of weaknesses and strengths in our practices, and to constantly improve.

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First place: Prescribing income—reimagining our ability to act on the most powerful determinant of our patients' health

This is a familiar story. The last patient of the day is a middle-aged man, not seen for some time, with lower back pain, which developed through years of working in a low-paying manual-labour job. A visit to the doctor was postponed, as it meant missing work. The pain is now incapacitating. Unable to function and having difficulty making ends meet, the patient is now drawing on his meager savings to pay rent. We work in a system that pushes us to focus on the symptom alone, so we write a prescription and perhaps try to help this patient access physiotherapy. Rarely can we go upstream of the problem to address the underlying reason: poverty and poor work conditions. The link between poverty and illness is irrefutable. Yet, many of us feel powerless or too overburdened to take action. No longer. There is a dangerous new idea out there that is about to challenge how we intervene in the factors that underpin the health of our patients. Since December 2013, the St Michael's Hospital Academic Family Health Team in Toronto, Ont, has been engaging in an innovative program. Through referrals and through proactive identification, patients living at or below the poverty line are identified and

referred to an income security health promoter. Working collaboratively with the rest of the health care team, the income security health promoter assists in navigating the complexity of federal, provincial, and municipal social safety nets to maximize patient access to income-boosting public benefits. Services for patients also include receiving employment support, completing income taxes, accessing free services, identifying subsidized housing, and improving financial literacy. To date, more than 200 patients have been assessed and treated. Patients, providers, and policy makers are starting to notice. Being both dangerous and disruptive, this idea has the potential to introduce an entirely new dimension to family medicine.

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA | LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

SECTION OF RESEARCHERS • SECTION DES CHERCHEURS

Tribune aux idées dangereuses

« Une idée qui n'est pas dangereuse ne vaut pas la peine d'être appelée idée ».
Oscar Wilde

Avez-vous une idée dangereuse sur la pratique clinique qui pourrait changer l'exercice de la médecine familiale? la prestation de soins de santé? la santé d'un patient?

La Tribune aux idées dangereuses, vous offre la possibilité en tant qu'innovateur de partager une idée importante qui passe inaperçue, mais qui devrait être diffuser dans la communauté de médecine familiale. Une idée dangereuse peut prêter à controverse, être très créative et nouvelle, ou encore aller à l'encontre de la façon actuelle de penser. Il faut cependant qu'il y ait un engagement à aller de l'avant, à vouloir faire une différence.

Chaque conférencier aura 3 minutes pour présenter son idée. Les membres de l'auditoire pourront ensuite soulever leurs objections, critiquer les idées et procéder au vote de l'idée dangereuse la plus puissante. Les idées seront publiée dans le *Médecin de famille canadien*.

Les propositions seront acceptées au **www.eiseverywhere.com/eselect/82068** jusqu'au **7 avril 2015**.

Les propositions seront choisies selon :
- leur originalité (une idée nouvelle?);
- le défi posé (est-elle véritablement dangereuse?); et
- leur capacité de diffusion (l'idée peut-elle faire une vraie différence?).

Les propositions doivent répondre aux critères suivants:
- être présentées en un seul paragraphe;
- avoir moins de 300 mots; et
- décrire une idée et comment elle changera l'exercice de la médecine familiale, la prestation des soins de santé et la santé des patients.

Quelle est votre idée dangereuse?