Other ways of knowing

Using critical discourse analysis to reexamine intraprofessional collaboration

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Common clinical scenario

Kevin is a 64-year-old man who works full time and takes medication for type 2 diabetes, high cholesterol levels, depression, and hypertension. When first diagnosed with diabetes, his previous family physician had referred Kevin to see an endocrinologist, whom he continues to see yearly. During his periodic health review, Dr Lee, his new family physician, notices Kevin's glycated hemoglobin (HbA_{1c}) level is above guideline-recommended targets. She reinforces the importance of lifestyle modification and suggests an additional glucose-lowering medication. Kevin has already taken time off work owing to chronic low back pain and arthritis. He is concerned that a new medication might interact with his other medications, causing him to miss more time at work. They make a shared decision to focus on alleviating his pain. When Kevin sees his endocrinologist for his yearly appointment, the endocrinologist notes the elevated HbA_{1c} level and asks Kevin why Dr Lee did not start the additional medication as recommended by guidelines. Rather than make recommendations to Dr Lee, the endocrinologist decides to prescribe a new medication and book follow-up appointments with Kevin every 3 months until Kevin's HbA_{1c} level is at target.

Successful management of chronic disease requires effective intraprofessional collaboration between family physicians and other specialist physicians.[1,2] However, prejudice, lack of trust and respect, and differing views of patient care impede the cultivation and maintenance of collegial relationships necessary for effective physician collaboration.[3-7] While consensus statements have defined core competencies to facilitate teaching and learning about intraprofessionalism,[2] more work is needed to promote models of physician intraprofessional collaboration in practice that value relationships and the unique expertise provided by family physicians.[5,8]

Critical discourse analysis

We suggest that perhaps theories from the social sciences, such as critical discourse analysis (CDA), might provide a valuable lens to explore problems in physician intraprofessional collaboration in new ways, toward imagining new models. Already, such social science approaches have proved useful for researching power and hierarchies in patient-physician encounters, prompting a shift away from physician-centric encounters toward an emphasis on patient-centredness, patient empowerment, and patient satisfaction.[9] Similarly, identifying issues of power, professional hierarchies, and conflict that counter the spirit of interprofessional care has been instrumental in shaping more efficient models of team-based primary care.[10]

Thus far, social science approaches such as CDA, which bring to attention issues of power and inequities that might otherwise go unnoticed, have yet to be used to understand the challenges in physician intraprofessional collaboration. Critical discourse analysis examines use of language to understand the boundaries for what can or cannot be said about a topic, and what roles people can or cannot play.[11] By making visible the historically locatable origins of dominant ways of thinking, talking, and writing about a topic, and the marginalization of other ways of knowing, CDA could illuminate the ways in which power relations and hierarchies between family physicians and other specialists are created and maintained. Once "previously invisible" problems are made visible, "newly visible problems can then be studied" from which "newly visible solutions can be implemented."[12]

Newly visible problems

We will now demonstrate how CDA can be used to examine problems in physician intraprofessional collaboration as depicted by the clinical scenario of the patient with diabetes. First, CDA makes visible that family physicians and other specialists might differ in their beliefs about and priorities within providing high-quality diabetes care. For example, Kevin's endocrinologist views the elevated HbA_{1c} level as a marker of inadequate care, thus justifying the need for an additional medication with less attention paid to other health issues. Kevin's family physician places value on helping Kevin balance living with diabetes in the context of dealing with his more pressing concern of back pain and arthritis, and stresses the importance of coming to a shared decision. By illuminating the presence of multiple "truth systems" about diabetes care, CDA generates new and important research

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questions about physician intraprofessional collaboration. For example, to what extent do family physicians and other specialists differ in their beliefs about diabetes care? To what extent do differing views of diabetes care affect the relationship between family physicians and diabetes specialists, and consequently, collaboration?

Second, CDA makes visible the extent to which diabetes guidelines set the terms and conditions around physician intraprofessional collaboration. For example, in the scenario the elevated HbA_{1c} level stimulates the endocrinologist to assume a more direct role in care, potentially affecting the relationship between Kevin and his family physician. Diabetes biomarkers (glucose levels, blood pressure, cholesterol levels) directly influence the referral-consultation process; biomarkers above target signal when a family physician should refer a patient to a diabetes education centre or diabetes specialist,[13] whereas biomarkers at or below guideline-recommended targets signal when a diabetes specialist should transfer care back to a family physician.[14] In contrast, the diabetes referral-consultation literature does not discuss the importance of physicians' roles in facilitating shared decision making or helping patients balance diabetes against other problems. By making visible how certain voices, roles, and expertise are legitimized (and others marginalized) in diabetes guidelines, new research questions can then be asked about how to promote the role and expertise of family physicians. For example, what is the unique expertise of family physicians in diabetes management? How could the expertise of family physicians be used to improve current referral-consultation models? In what circumstances should diabetes specialists ask family physicians for advice?

Third, and arguably most important, CDA illuminates the potential for guidelines to not only set the terms for how family physicians and other specialists should collaborate, but to set them in a way that reinforces a power differential. In the scenario, the decision of Kevin's endocrinologist to see him more frequently implies doubt cast on Dr Lee's ability to provide care to Kevin. Despite well documented concerns raised about guideline-based care (for example, lack of patient-centred content in guidelines,[15] lack of primary care representation on guidelines committees,[16] and lack of consideration of the elderly or those with comorbidities[17]), family physicians continue to be judged by the extent to which they adhere to guidelines.[18] As a consequence family physicians are constructed, albeit unintentionally, as a problem for which other specialists are constructed to be part of the solution directly through consultation or shared-care models, or indirectly through continuing education and other forms of knowledge exchange.[13] Thus, by making visible unintentional effects of guidelines, CDA helps generate important research questions about the roles, identities, and scopes of practices of family physicians. For example, to what extent does referring a patient deemed "uncontrolled" reinforce a hierarchical relationship between family physicians and diabetes specialists? What are the negative effects of guidelines on the roles of family physicians and their relationships with patients? To what extent is collaboration affected?

Beaulieu argues there is a need to "invent" new models of collaboration between family physicians and other specialists.[19] We argue that theories and methodologies from the social sciences such as CDA, already used to untangle problems encountered in patient-physician relationships and *inter*professional collaboration, can make visible how the expertise of family physicians has been marginalized and undervalued in current constructions of physician *intra*professional collaboration. Critical discourse analysis can provide a valuable framework for teaching and researching aspects of collaboration that have yet to be explored, including how guidelines and other decision-making tools reflect certain beliefs about health at the expense of other beliefs, how guidelines might be inadvertently creating and reinforcing power dynamics between family physicians and other specialists, and how the resultant hierarchical relationship might impede effective collaboration. Only once these previously hidden problems in physician intraprofessional collaboration are identified can their changeable nature become apparent, and subsequently the discovery of appropriate solutions becomes possible.

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Competing interests
None declared

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