Rediscovering the rewards of teamwork

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When I started my academic family medicine career in 1994 at Women's College Hospital in Toronto, Ont, apart from delivering babies, I practised full-scope family medicine.

At the centre of it was a 10-bed family practice inpatient unit on the 10th floor of the hospital. The unit was staffed by a dozen or so family physicians, including me, and our family medicine residents. Each month, 3 staff members and the residents on their family medicine block rotation took turns looking after the sickest of our own patients and those of our family medicine colleagues in the community who were affiliated with the hospital. Referrals for admission came from our small emergency department, also staffed mainly by family physicians. Residents took first call to the emergency department and the inpatient unit, but were also on call for obstetrics and community calls from our patients. Together we rounded on patients from 7:30 AM to 9:00 AM Mondays, Wednesdays, and Fridays, and on weekends for whomever was on call. Often, we rounded again after our afternoon clinics ended, usually on those who were the sickest. Bedside teaching was an important component of our work.

Most of the patients we admitted were older, with comorbid medical conditions, social isolation, and frailty. Fortunately, we had backup consultation available from our specialist medical and surgical colleagues, as well as a team of dedicated nonphysician health professionals including a social worker, an occupational therapist, a physiotherapist, a dietitian, and a clinical nurse specialist in geriatrics. Discharge planning for some of the most complex patients began the day after admission, with the input and support of this experienced larger team. Our outcomes compared favourably with those of our internal medicine colleagues.

For family medicine staff and residents, the work was physically, mentally, and sometimes psychologically demanding. But it was also deeply rewarding. Most rewarding of all, however, was the sense of working together as a team supporting and helping each other, and a deeper sense of connection and camaraderie with our specialist colleagues.

The inpatient unit closed in the early 2000s after our hospital merged with a larger academic hospital that had no culture of family physicians caring for their own patients in hospital. Much of that sense of connectedness and being part of a highly effective team was lost.

On April 8, 2020, Women's College Hospital (where I now practice less-than-full-scope family medicine) launched an innovative clinic aimed at providing virtual care to patients diagnosed with coronavirus disease 2019 (COVID-19) (**https://covidcareathome.ca**). One of the first challenges that the program faced was how to staff it. Much was still unknown about the natural history of the virus and the earliest published case series from China[1,2] came from hospital settings where there were high rates of serious illness and death. One of the biggest concerns was how to predict in a timely way which patients would progress to respiratory distress requiring urgent care, as there are no good predictive tools.[3]

In spite of the substantial uncertainties, the program was developed using a model of remote (virtual) monitoring based in primary care.[4] As part of hospital redeployment, the program was staffed with 6 family physicians, 5 of whom, including me, had worked together for years on our old inpatient unit and for almost 30 years together in our family practice clinic. Crucial to the operation of the program has been the involvement of senior family medicine residents; specialist physician backup from 2 general internists, a respirologist, and 2 psychiatrists; and a dedicated group of nonphysician health professionals including nurses, nurse practitioners, and social workers. Given the clinical uncertainties and lack of knowledge of this new disease, the early weeks of the program meant creating twice-daily virtual rounds at the beginning and end of each day, weekly case conferences to discuss and learn from the more complex patients, and building in clinical, educational, and programmatic evaluation and research.

All of the approximately 150 patients we have cared for in the program so far were referred from the hospital assessment centre and had positive results for COVID-19. Although many had risk factors for poorer outcomes, only a handful have been sent to hospital, and only 1 was admitted for a short period of observation and support. None have died. By the time they were discharged most had almost fully recovered.

For me and my colleagues, although the work has been physically, mentally, and sometimes psychologically demanding, it has been a case of burnout, interrupted.[5] We have rediscovered the joy of working together as a team supporting, helping, and learning from each other in the face of a frightening and destructive pandemic, leveraging our years of experience as generalist family physicians, responding to the needs of the community, and applying our adaptive expertise.

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