Change is not possible unless it is feasible

Dr Brian Hutchison reflects on how to improve the health care system

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On Friday, August 16, 2024, 3 days before he died, Dr Brian Hutchison kindly agreed to sit down with me virtually for this interview. Brian co-authored a research article in the May issue of *Canadian Family Physician* entitled "Assessing the impact of Canadian primary care research and researchers. Citation analysis,"[1] which has been widely read. Brian then interviewed 5 of the most-cited primary care researchers for a series in *Canadian Family Physician* called Impact Interviews (**page 750**),[2-6] in which the researchers shared their wisdom with Brian and our readers. Brian and I enjoyed a wide-ranging conversation about his life and work as a family physician, primary care researcher, and health policy expert. The following is an edited transcript of our conversation in which Brian shares his journey, his reflections, and his wisdom about the future of primary care, primary care research, and the Canadian health care system. It was a great honour and a privilege to have this chance to speak with him.

How did your work as a practising family doctor lead you to research and health policy work?

When I started practice it became clear to me that there was this discrepancy between what we could achieve as family physicians and what we were achieving. And I think we all knew it. Part of it was the heritage we had of patriarchal, hierarchical approaches to clinical care, where we saw our job as identifying what patients needed in the way of diagnostic and therapeutic interventions. Our job was to say, "Here's what you need. How can I help you get it?" And if there was resistance, our job was to eliminate that resistance and persuade people to do what you thought best for them. I think the most common terminologies were things like a "nonadherent" or "noncompliant" patient. It was the job of the patient to do what you asked them to do. It very quickly became clear to me that that was a stupid premise and that our job was much more of a broker than of a marketer of medical treatments and diagnostics.

And really all we had to do was try to work toward understanding and accommodating people's values and preferences. Not just medical evidence. We also inherited a system where research-based evidence was not prominent in people's thinking. It was the experts, the gurus, who knew from experience, I think.

We used to call that "eminence-based medicine," I think.

Yeah, exactly. So, my first challenge in practice was kind of coming to terms with this, and it took me a while. I learned from some unpleasant experiences where I was getting mad at patients because they weren't doing what I told them, and of course they picked up on that and it tainted the relationship, and it took a while to really straighten myself out. But I knew that, you know, I was motivated primarily to do a better job.

So that on the clinical side is going on, but there was a parallel on the policy side where we knew a lot of about some of the population health, equity-generating kinds of approaches that could be effective. But, again, they needed to be at a level in the system where it wasn't just a fragment of the population getting access to new innovations in organization, funding, and delivery of primary health care. And so here we go. We've got at least 30 years of advocacy at both levels and not very much progress anywhere.

When you reflect on 4 decades of clinical practice, research, and policy work, what insights would you like to share with readers?

I could start virtually anywhere, but I had an interesting thought as I was thinking about this interview—that there's a real parallel between the world of clinical care and health policy around the lack of progress in spreading and scaling the kinds of innovations we know work from evidence and internationally. And we've known about a lot of those things for at least 3 decades, if not longer.

Why do you think those changes haven't come about?

I think it hasn't happened because we don't spend enough time asking, "Well, why doesn't it happen if we know what to do? Why aren't we doing it at the scale where it would really affect the population level as opposed to the place where the trial is done?" Or the innovations are partly implemented but not evaluated to know whether the implementation has been successful and whether it's something that deserves to be spread at the system level.

So that came to me today as that was an interesting parallel with a common cause, and the common cause was an unwillingness or inability to invest in the kind of infrastructure and support that would be needed for

the primary care sector and health care more broadly to move forward with innovations that are likely to make a real difference to the health of Canadians.

Are there other, systemic barriers to change?

It's what I would call "the elephant outside the room." It's not within health care. The problem is the lack of resources that are being invested in society—whether it's health care or education, or addressing social disparity, migration, or the climate crisis. Almost anything you look at that we're faced with—threats to life as we know it—are not going to be addressed within the current framework.

It's not going to be easy because there is this problem of lack of resources, which I think is based in our economic system, which is a neoliberal capitalist version that honours low taxes and small government. There's a broad consensus that we don't just have to move the chess pieces around, there needs to be more chess pieces and different kinds of chess pieces. [It's] not easy to say, "Oh, no problem, let's move away from market-based solutions," but at least we need to acknowledge that there's where the problem is. Again, it's not within health care, you know. The problem isn't that we aren't doing the right research. We could certainly do better research and with more persuasive and convincing methodologies, but we can't fix the problems in the system from within. There's got to be this investment.

What do you think is or should be the role of researchers in advancing primary care reform?

One of the things that this does bring up is what is the role or the potential roles of researchers and how to relate to the public. One of the initiatives that the Canadian Health Services Research Foundation [(now known as the Canadian Foundation for Healthcare Improvement)] undertook when Jonathan Lomas was the CEO [(chief executive officer)] was this "listening for directions" exercise. I didn't think it was ever implemented very well, but the concept of trying to build consensus was good. It was just to bring key stakeholders together, including residents of Canada, to build a consensus. Patients, providers, researchers, and policy-makers getting together to look at what we need to do across the spectrum of research from clinical care to health policy that's going to serve the needs of the population. So, we're not having competing views all the time and people can hear each other and say, "Here's the common ground—let's move ahead on that."

How can researchers support that?

I wrote an editorial for *Healthcare Policy* in which I looked at the role of researchers, and I was conservative at the time around how far they should go as public figures.[7]

I've been focused very much on trying to help identify what could make things work better, but there's another level in the end. We've been long in it, and I certainly became part of it, but it is the whole business of dissemination of research to those who might take advantage of it. The CIHR [(Canadian Institutes of Health Research)] has moved ahead on that and lots of other granting organizations have, too. Lots of researchers have moved forward on that. Engaging researchers with stakeholders is a good sign for research. There has not been so much progress in that regard, but we're starting to see some movement. But how do you reach the public on this so that they do understand primary health care and they do realize that there's more to be done?

You have done research and engaged with policy-makers for a long time. Are you optimistic that we will achieve the kind of primary health care system that Canadians need and want?

Yes. Sometime—this will not be soon—but yes. I do remain optimistic. One message that I want to get across is that change in the system isn't possible unless it's feasible, and building consensus across the key stakeholders is necessary to make change feasible. I do see some progress in that regard. And we shouldn't underestimate the value of incremental changes.

And I've had some great personal experiences. As a patient with widespread prostate cancer, the care I've received has been superb and people are so kind and generous, whether they're neighbours, friends, family. It's been such an uplifting experience to go through this and realize how decent and caring most people are. And people work so hard to do the best they can.

So, it's been these things which make me hopeful. I think we're really done in if we lose hope here—I mean even hoping for some small change. And that you can work on.

There's a quote that's attributed to Arthur Ashe. I don't know whether it's correctly attributed, but it's attributed to him: "Start where you are; use what you've got; do what you can." I think that's a message for all of us—we can all do something.

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None declared

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