System Issues, Policies and Practices Affecting Physician Intraprofessionalism

Background commissioned by the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, and the Canadian Medical Association to inform future discussions and work.

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The views, findings and opinions expressed herein do not necessarily represent the views of the Royal College, the CFPC, and the CMA.
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Introduction

The College of Family Physicians of Canada (CFPC) and The Royal College of Physicians and Surgeons of Canada (RCPSC) addressed the issues surrounding the relationships between physicians in a two day Colloquium in 2006, with the goal of improving physicians’ working and learning relationships to enhance patient care, and patient and physician satisfaction. The outcome of this Colloquium was a conjoint discussion paper entitled “Family Physicians and Other Specialists: Working and Learning Together” and in the creation of a committee in 2007 called: the Collaborative Action Committee on Intraprofessionalism (CACI) whose mandate was to oversee productive action on the recommendations from the discussion paper. The Canadian Medical Association (CMA) became a third partner of CACI in 2010.

Five main themes were considered for action: Collegial Relationships, Practice Environments, Changing Models of Care and Collaboration, Education, and Physician Resourcing. In addition, the enabling roles of Information Technology / Management and Communications Skills in improving intraprofessional relationships were considered. At the time, the committee recognized that system-wide change can be difficult to implement and the importance of starting transformation with small manageable pieces. They also expressed a desire to focus their recommendations on those activities that relate to the mandates of the two Colleges. This led in 2008-2011 to the following accomplishments:

- Development of the Intraprofessional Core Competencies to become the reference in education and training
- Integration of the ICCs in the Accreditation standards
- Completion of a referral and consultation guide for physicians to use in education and practice (available on CFPC and Royal College websites)

In the May 2011 meeting of CACI consensus was that:

- CACI had met its deliverables and that CACI as it currently exists should be retired.
- There was support for a smaller group to continue this work in specific areas (Quality Improvement and Systems issues related to intraprofessionalism.
- More can and needs to be done in the area of Quality Improvement (QI) as it relates to intraprofessionalism (e.g., how could we redefine the referral-consultation process to improve quality care, and what should we measure to follow our progress in this regard?) It was recognize that there are many groups in all three organizations involved in QI at the moment. The committee recommended that intraprofessionalism could be added as an element of quality. For example the Royal College is looking at Clinical Practice Redesign which incorporates high-quality referral/consultation practices.
- More can and needs to be done to address systemic issues; to identify and address system barriers and enablers to good physician relationships. It was also recognized that to accomplish this would require:
  - A literature review possibly involving key informant interviews
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- Stakeholder consultation (via a Summit or Colloquium) including regional health authorities, licensing bodies, provincial governments, patients to determine key areas of focus
- A new working group consisting of strategic organizations based on the issues and priorities identified at the Colloquium.

**Purpose**

To examine and synthesize current evidence and observations in the literature on system’s issues, policies and practices that facilitate or hinder effective intraprofessional relationships, and supplement with key informant interviews.

**Methodology**

The overall project was guided by a Steering Committee comprised of a representative from the Royal College of Physicians and Surgeons of Canada (RCPSC), the College of Family Physicians of Canada (CFPC), and the Canadian Medical Association (CMA).

The literature search was comprised of three strategies. The first was a search of peer reviewed literature using EBSCO Host research databases including MEDLINE, CINAHL Plus and Health Policy Reference Center with a ten year retrospective (2002-2011). The subject heading used included the following terms:

- ‘Physician collaboration’
- ‘Intraprofessional collaboration’
- ‘Physician relationships’
- ‘Physician to physician communication’
- ‘Primary and specialist physicians’
- ‘Primary and specialist collaboration’
- ‘Collaborative care’
- ‘Collegiality’
- ‘Collaboration’

The abstracts obtained from this search were narrowed to potentially relevant articles which were obtained and reviewed.

The second strategy involved a targeted search of websites of provincial/territorial/national medical regulatory bodies and medical professional associations, as well as websites of national medical education organizations. Key search words/phrases included physician relationships; communication; collaborative; collaboration; referral patterns; intraprofessional; intra-professional; physician teams; team; and collegial relationships.

The third strategy was a search for grey literature at the international level. This included a review of websites of the World Medical Association, Australian Medical Association, German Medical Association, Swedish Medical Association, and the British Medical Association. The sample of countries was chosen for their similarity to Canada’s healthcare system.
Additional sources were also identified via citations offered in reference sections of relevant articles and documents. The scope of the search was limited to English documents only.

Fourteen key informant (KI) interviews were conducted via telephone to clarify and seek opinions on barriers and enablers identified in the literature review, as well as identify examples of Canadian 'success stories' and their enabling factors and professional development initiatives targeted at improving physician intraprofessional collaboration. A convenience sample was chosen with an effort to stratify the sample according to sex, geography, speciality (family medicine versus other specialty), and location of education (Canadian graduate versus international medical graduate (IMG)). In addition, it was felt important by the steering committee to garner the perspective of medical residents and Vice Presidents of Medical Affairs.

The breakdown of the convenience sample is as follows:
- 5 family physicians
  - Divided between male and female
  - Divided between urban and rural & remote
  - 1 is an IMG
- 5 specialists
  - Divided between male and female
  - Divided between urban and rural & remote
- 2 residents
- 3 VPs of Medical Affairs in RHAs or academic health centres/networks, one of which is an IMG

The interview guide can be found in Appendix A.

Findings

What Constitutes Collaboration?

To begin, a review of the definition and conceptual framework of ‘collaboration’ was conducted. Berendsen et al (2010) propose that general practitioners and specialist collaboration is comprised of five domains: organisation, communication, professional expertise, image and knowing each other. Foy et al (2010) have proposed a conceptual framework to delineate the core features and associated features of collaboration between primary care physicians and specialists. Core features included interactive communication, quality of information, needs assessment and joint care planning. Beaulieu et al (2009) examined how collaboration between family physicians and specialists was conceptualised as a competency and experienced in residency training curricula in four faculties of medicine in Canada. They found that the training objectives were phrased in very general terms, lacking specificity and uniformity across programs. All of the residents interviewed identified referral/consultation skill as the key collaboration competency but stated that for the most part, learning intraprofessional collaboration was not formalized in clinical rotations. Residents identified the following as to what constitutes effective collaboration: clinical relevance of the referral, good communication skills, and clear definition of responsibilities.
Boon and colleagues have developed a conceptual framework that describes seven different models of team oriented health care practices which includes collaborative practice defined as practitioners who normally practice independently from each other and share information concerning a particular patient who has been (is being) treated by each of them. Each model occupies a position on a continuum from non-integrative to full integrative approach to patient care. Communication between and among individuals, respect for diversity of opinions of practitioners, and attempts at making consensus based decisions among practitioners are key components and increases as one moves from left to right along the continuum.

Clements et al point out that teamwork and collaboration are often used synonymously in casual discussion but they are not the same. Collaboration is both a process and outcome and can take place whether or not a health professional considers themselves part of a team. However, effective teamwork rarely happens without collaboration. Teamwork requires an explicit decision by the team members to co-operate in meeting a shared objective.

Collegiality has also been seen as a key element of collaboration. According to one senior medical officer, collegiality is comprised of a number of values that underpin any professional relationship: respect, a sense of mutual collaboration and trust, openness, transparency, a common focus on the patient, and compassion. She goes on to explain that the resulting behaviours include mutual respect even amidst differing opinions, understanding that the common goal is good patient outcomes, non competitiveness in medicine, correcting mistakes through quality assurance in a non-blaming environment and full and open communication. Compassion and communication are identified as two concepts key to building collegiality.

The Collaborative Action Committee on Intraprofessionalism has developed Core Competencies for Intraprofessionalism which has been distributed to medical schools across Canada. Their uptake into medical curriculum should facilitate greater intraprofessionalism in new physicians.

In addition the Canadian Medical Association has created a new Student Leadership Curriculum which addresses personal and communication skills needed in today's collaborative practice environment. While the competencies are designed for interprofessionalism, they are will suited to enhance intraprofessional relationships.

**Enablers and Barriers**

The literature review resulted in the emergence of a number of system issues, policies and practices which serve as enablers/facilitators or barriers/hinderers. Each of these is discussed below.

**Remuneration**

Remuneration models for consultation/collaboration with other physicians were a key theme in the literature which can serve as both an enabler and barrier. Reimbursement policies were cited as a system deterrent to collaboration from specialists to primary care physicians in diabetes care in a Canadian study. Similar results were found in a review of shared care in mental illness. Specifically, the traditional physician fee for service (FFS) payment system is seen to impede
collaborative care in general. A Canadian study of the experience of collaboration in residency training curricula found that fee schedules that do not permit reimbursement for telephone consultation was a barrier to effective collaboration. “Governments are afraid of making medicine more efficient by paying reasonably for telephone/email/fax communication between specialists/GP/FPs that would obviate the need for face-to-face consults that are often wasteful of time.” According to O’Malley et al (2011), most current compensation methods do not incentivize communication, especially in the FFS environment.

Furthermore, Oandasan et al (2006) note that no financial incentives exist that tie funding to collaboration and teamwork efforts unlike that of other countries. Over the past decade, experience has been gained in Great Britain and the Netherlands in the development and organization of new specialist-general practitioner collaboration. Their experience points to collaboration barriers of structure, procedures, finance and legitimacy at system and institutional levels. Experience in the US points to payment reform to compensate providers for currently unreimbursed care management and coordination activities as an essential component of the patient-centred medical home.

Another US study found that specialists’ attitudes towards the coordinating role of primary care physicians are influenced by financial interests that may be threatened by referral restrictions. Payment models such as salary and capitation that essentially eliminate the link between volume of care and the specialist’s income generate a more favourable view of the gate keeper role of primary care physicians. Based on their findings, the authors suggest that alternatives to FFS payment models may generate a common sense of purpose between primary care physicians and specialists.

Many specialists believe that new forms of collaborative practice do not profit the specialist noting that office hours produce more revenue than collaborative projects even when one is on salary. On the other hand, one Canadian surgeon found a consultation outreach clinic held in collaboration with family physicians was in fact an opportunity to capture an increased market share of patients and ultimately an increase in his remuneration.

Clements et al argue that “while project based funding for collaboration can stimulate change at the project level, it does nothing at a systemic level, often making it difficult, or impossible, for change to become permanent and sustained.”

Amendments have been made to various FFS agreements across the provinces over the years to provide remuneration for collaboration. For example, in British Columbia, in 2006 the Community Patient Conferencing Fee was introduced to support the care needs of frail elderly patients requiring palliative care or end of life care, patients with mental illness or those with complex comorbidities. The aim of the fee is to better support general practitioners as they work with patients, their families and other health care providers in the ongoing management of patients in facilities. In addition a special committee was tasked with creating new fees to enable shared care and appropriate scopes of practice among GPs, specialist physicians and other health care professionals.

Almost 70% of the key informant interviewees (KII) identified remuneration models as either a barrier or facilitator of effective intraprofessional collaboration. FFS was generally seen as a barrier, although two KIIIs noted that there is now a fee code in their province for collaboration/consultation among physicians. One of the
Interviewees noted that no high performing countries have FFS. Two KIIs stated that remuneration should not come into play. One commented on the tendency of physicians on a capitation model not to see additional patients.

Three of the KIIs raised a different aspect to remuneration suggesting that poor relations between physicians are in part attributable to physicians focused on how they can make more money and not on patient centred care. One physician commented that if the physicians are working together for the patient, there are no problems; problems arise when a physician is in it for the power, the money or themselves. One noted that physicians complain of the workload but they don’t want more physician positions created as it cuts their share of the pie.

**Liability**

Malpractice and liability laws are seen as formidable barriers to effective teamwork. Despite the move to greater teamwork and collaboration in Canada through new models of care, current malpractice legislation places responsibility solely on individuals. Clements et al suggest that regulations that support teamwork would refocus the ‘culture of blame’ to a culture of patient safety. Psychological safety among team members that enables them to discuss and learn from mistakes and to challenge their colleagues when required was similarly found to be a strong facilitator of collaboration in an Australia study on effective teamwork.22

A US study on coordination between emergency and primary care physicians found that liability concerns may keep providers from participating fully in care coordination.23 The authors note that even if an emergency physician consults with the primary care physician of a patient presenting to emergency, the emergency physician must accept that the legal responsibility for a bad outcome following a patient's discharge will likely remain theirs alone. “Failing to address emergency providers’ concerns about controlling their malpractice liability risk will limit any attempt at encouraging emergency physicians to coordinate with primary care physicians.” (p.10)

Physicians interviewed for an article on collaborative care stated the most successful and effective collaborative care teams have a formal agreement where the roles, governance structure and responsibilities of each team member are clearly spelled out, with corresponding legal provisos discussing their various levels of responsibility.24

“Although some have suggested medical liability concerns are a barrier to the implementation of collaborative care, the CMPA [Canadian Medical Protective Association] believes, while there are important issues that must be addressed, the principal elements of the solution already exist within the current medical liability system.”25 (p.11) They state that “efforts to amend the current law to introduce the concept of team liability rather than individual liability should be discouraged as a “team” has no legal status, and any change to this would be highly disruptive and time-consuming... there is no need to risk the viability of the Canadian health care system by introducing no fault or enterprise liability alternatives.” (p.10)

Only one of the KIIs raised the notion of an increased risk of liability working in a team environment as a potential barrier to effective intraprofessional collaboration.
Role Clarity

The need to define a clear role for family physicians and specialists is cited in numerous articles. A thematic analysis of research on effective primary care and specialist mental health services found that role clarity was the most cited factor. A lack of clarity was also identified as a barrier in a study of the interface of primary and specialty care in end of life care. Han and Rayson (2010) found that the major challenge confronting primary care and oncologists is to determine their respective responsibilities with respect to one another with this challenge being heightened at the end of life. The authors note the clinical tasks involved at this stage fall legitimately within each specialty’s domain of expertise and interest. Manca et al (2011) found that negotiation of roles and responsibilities to develop flexible relationships with a clear understanding of roles was important to good collaborative physician working relationships.

Sometimes that lack of role clarity is created by overlapping scopes of practice between specialists, and specialists and primary care physicians. For example, a US based study found that as the field of plastic surgery and other areas of medicine continue to evolve, additional education of physicians, including family practice physicians, is required on the scope of plastic surgery practice. In the study, family practice physicians were asked to choose the speciality they perceived to be an expert for six specific clinical areas. Their responses varied greatly.

According to the Canadian Medical Protective Association, Health professionals should clearly understand the scope of practice of those with whom they work. Where scopes of practice within a team overlap, there should be well-documented delineation of responsibilities. The overall responsibility for health care decisions should be clearly specified and understood by all. Effective and efficient communications within the team, with the patient and across teams will take on added importance; this should be supported by clear documentation of care.

Four of the KIIIs explicitly identified a lack of role clarity as a barrier to effective intraprofessional collaboration. However, many others implicitly identified it as a secondary component as it relates to shared practice guidelines, care pathways, consultation/referral processes, etc.

Differing Cultures

A 2011 study by Manca et al found two distinct cultures in medicine: a specialist culture and a generalist or comprehensive culture. Each is characterized by distinct knowledge, skills and values with the specialist one described as focused and the other comprehensive. The specialist culture focuses on technology, concepts and specific details of diseases and organs; the generalist on patients, not diseases, and comprehensive clinical skills and services. “In a system that valued technology and specialized knowledge and skills, the specialist were better able to control resources, set boundaries and influence learners. This precipitated a culture of protecting valuable specialty resources, increasing physician isolation and generalists feeling they were left holding the bag.” (p. 580)
One of the KIIs specifically raised the issue of distinct cultures between family physicians and other specialists. They noted that the two groups often do not share a common language which impedes effective collaboration.

**Workload/Time**

Clements et al suggest that the current shortage of some health professionals creates a workplace environment where few people have the time, energy or will to experiment with new collaborative models of care delivery.\(^{38}\) Inadequate time is frequently cited by specialists as the reason not being able to collaborate, highlighting their already extremely busy schedules comprised of clinical, research, educational and administrative activities.\(^{39,40}\) In collaborative practice models specialists attribute the lack of time to too much discussion, too much paperwork and too complicated a project.\(^{41}\) Lack of time was also cited as a barrier to effective collaboration by medical educators in a Canadian study of residency programs\(^ {42}\) and by a US study on collaboration between emergency and primary care physicians.\(^ {43}\)

Time pressures were also cited as a barrier to collegiality and collaboration in a series of interviews with Canadian physicians.\(^ {44}\) According to the Ontario Medical Association, physicians are overloaded with a combination of work and family stresses which leads to decreased job satisfaction and decreased physicians’ motivation to behave professionally and collegially.\(^ {45}\) Results from the latest National Physician Survey (2010) show that physicians are ‘on the job’ approximately 83 hours per week (inclusive of on-call), a heavy workload by any standard.\(^ {46}\)

Approximately 70% of the KIIs identified time and workload as a barrier to effective intraprofessional collaboration. Issues such as no protected time to make calls, not enough administrative support and the shortage of doctors were cited. One of the physicians noted it was a huge issue; another one stated it was a minor factor noting that there was also an element of self pity enveloped in this issue. “Doctors are well paid; get over it.”

**Wait Times**

Wait times has dominated health care policy discussions for a number of years. “While there has been an encouraging effort to reduce the length of time a patient has to wait for care, there has been less focus on addressing the real and potential concerns associated with the accountability and liability issues associated with managing wait times.”\(^ {47}\) The current lack of clarity as to “who is responsible for what” creates potential risk for all involved, including physicians. Documentation from CMPA outlining how physicians may be liable for adverse outcomes resulting from excessive delays in the delivery of medically necessary care has caused many specialists to take measures to limit their waiting lists. The majority of these include restrictions on the referrals they accept which has negatively impacted the referral/consultation process, a core element of physician intraprofessionalism.\(^ {48}\) CMPA outlines a number of activities for the government, health authorities and healthcare facilities, the medical profession, as well as for individual referring and accepting physicians to contribute to improved accountability and liability in regards to wait times.

One success story in regards to the primary care-specialist referral process in the context of wait times is the Specialist Directory in Saskatchewan.\(^ {49}\) It helps family
doctors search for a surgeon based on wait times, procedures performed or the location where the patient wishes to have surgery. The Directory is updated weekly.

None of the KIIs raised concern with the liability aspect of wait times as a factor in intraprofessional collaboration. Instead they grouped it in with workload and lack of time due to such lengthy wait lists.

Three of the KIIs suggested how wait times could be reduced: more appropriate referrals, an acknowledgement by physicians that others can do some of their work (i.e. physiotherapists can do some of the work of orthopaedic surgeons), and dealing with the demand through process flow management.

Communication

*Lack of Direct Personal Contact/Personal Relationship*

A number of studies, in particular those focused on mental health, point to face to face contact between GPs and other specialists as a facilitator of effective physician to physician collaboration. A study by Fredhiem et al (2011) identified problems with phone calls between GPs and mental health professionals. The mental health professionals, including psychiatrists, expressed a need for physical meeting places with GPs. Face to face contact between physicians and interpersonal knowledge were seen as key to effective collaboration in mental health. A similar result was found in a study of mental health care in Hamilton, Ontario. A study from the Netherlands found when mental health professionals had face to face contact with the GPs, results included significantly higher satisfaction with services among general practitioners, shorter referral delay, reduced time in treatment, fewer appointments and lower treatment costs. However, in rural and northern areas with shortages of specialty services, face to face meetings between GPs and specialists may not be feasible. Jong and Kraishi (2004) found that videoconference is preferred to visiting clinics and email as method for rheumatology consultation services in rural Canada. It was found to be cost-effective and promoted knowledge transfer between the rheumatologist and the referring physicians.

Numerous physicians have mentioned the loss of direct interaction between general practitioners and other specialists, and the negative impact this has had on providing quality care. Salerno et al (2007) found there is no substitute for direct personal contact between consultant and primary physician. A similar finding was found in patient handoffs of hospitalized patients. Qualitative research by Berendsen et al found that both GPs and specialists feel it is important to know each other personally. Specialists stated that it is difficult to gauge the knowledge of the GP if one doesn't know the GP. The importance of personal one-to-one interaction between the geriatrician and hospitalists and other referring physicians was reinforced in a study by Sennour and colleagues.

The lack of direct personal contact between physicians is found in the literature to be a result of a shift of family physicians from hospitals to private offices and community settings. This phenomenon was mentioned by participants at the 2006 CFPC-RCPSC Colloquium and subsequently affirmed in a study by Beaulieu et al which noted that family doctors leaving the hospital has hindered their relationships with specialists. Another study found that the increasing use of hospitalists has reduced the frequency of communication between emergency and primary care physicians. The authors argue that prior to the widespread use of hospitalists;
primary care physicians would generally admit patients to the hospital and manage their care there.62

A physician in Alberta described the situation as one in which the population swelled and pressures on inpatient beds grew dramatically.63 It was subsequently felt that community physicians were not aware enough of the inpatient pressures to independently assess the need for admission of patients, so they were required to clear all admissions with ER physicians. This change discouraged family physicians from maintaining hospital privileges and eroded primary and specialist care relationships. Primary care and specialist physicians who know the patients were disempowered while decisions were imposed on ER physicians working a very stressful environment.

Family medicine programs moving their residents out of teaching hospitals into community based training was also found to be attributable to the lack of generalist-specialist interaction.64

Over 60% of the KIIs stated that not personally knowing the other physician is a significant barrier to effective collaboration. Face to face interaction is very important to building physician relations. Many mentioned the lack of a physician’s lounge and the loss of family physicians from the hospital environment. One individual stated “You can’t trust someone you don’t know.” “You ignore those that you don’t know.” This in turn affects the referral process. Several individuals stressed the importance of shared physical space or co-location.

Several KIIs mentioned the lack of awareness of specialists in their area and the need for specialist services compendium/directories with contact information and practice/subspecialty interests.

**Discharge, Referral and Consultation**

The most common means by which doctors exchange patient information is through referral, consultation, and discharge summaries. These are considered important tools for primary care provider-specialist communication and intraprofessionalism. Numerous articles point to the need to improve both the quality and timeliness of these tools. For example, the quality of discharge letters was found to be a barrier to good professional interaction between general practitioners and general hospital physicians in Norway,65 and GPs and specialists in the Netherlands.66 A US study arrived at similar findings: discharge summaries were not available to the primary care physician in a timely manner and often lacked important information.67 Even when the referral is facilitated by an HER (e-referral), there are issues of ambiguity in roles and responsibilities, lack of standardization in referral processes, inadequate resources and lack of institutional referral policies.68 Several interventions were found to improve communications – computer generated discharge summaries, using patients as couriers and a standardized format for the discharge summary. Brez et al found that a structured discharged letter was thought to achieve improved communication.69

Similarly, the quality of a GP’s referral letter has been identified as an issue.70,71,72 And few GPs feel the specialist’s reply letter arrives in a timely manner.73 Sibert and colleagues identify many issues with the consultation process including the lack of a specific reason for the consultation, unclear follow-up plans, results of consultation
not communicated, among others. They propose that inadequacy in consultation skills results in strained relations between physicians.

Starfield and colleagues suggest that consultation with specialists directly, rather than through the patient, may be more efficient overall. They highlight trials of teleconsultations or outreach sessions (providing education, support and strategic planning) by specialists in primary care settings as a promising alternative to referrals. They also encourage professional associations to re-evaluate the roles of specialists, suggesting that for many conditions, consultants might better serve as consultants to the primary care physician rather than provide direct care to individual patients.

The referral–consultation process is a central component of intraprofessional relationships between physicians. In recognition of this, in 2009, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada developed a Guide to Enhancing Referrals and Consultations Between Physicians.

More than 60% of the KIIIs identified concerns with consultation and referrals as a barrier to effective intraprofessional collaboration. They validated the literature pointing to concerns with the process, the quality of referrals, and the need for structured/template referral/consultation letters that are developed jointly by family physicians and other specialists. One interviewee raised the idea of a web based source of national standardized referral forms for each speciality in Canada, developed jointly by the specialty associations, including family medicine.

According to the College of Physicians and Surgeons of Ontario, communications is receiving an explicit focus now in medical schools. Students are learning in an experiential way to communicate with patient, between peers, and within and across teams. They note that new guideline for educators being developed that will centre on communications competencies and abilities. This observation is echoed by another article which notes that communications being treated as a clinical skill and competency in communication being ingrained throughout the entire delivery of medical education is perceived to facilitate better intraprofessionalism. Similarly there is an increase in the number of courses in medical schools that employ small group, problem based learning, which by their very nature foster communication skills.

**Accessibility by Telephone**

Several studies found that challenges with telephone communication serves as a barrier to effective physician collaboration. Some stressed the value of real time physician to physician communication via telephone but found it very time consuming and frustrating trying to reach a colleague or waiting for someone to call back. Others cited the lack of access to up to date telephone numbers or ‘private’ numbers for their colleagues and suggested allocated times for telephone consultation to facilitate physician collaboration.

The findings in the literature were validated by 40% of the KIIIs who spoke of the need for protected time for telephone calls and suggested the need for more asynchronous means of communication.
**Health Information Technology**

The use of health information technology (HIT) was associated with higher reports of receiving and sending communication by specialists. It has also shown to benefit communication at the hospital and primary care interface by sending hospital reports directly into the primary care setting electronic medical record (EMR) in a very timely manner. Sharing information through an electronic medical record can enable effective collaboration between primary care and specialty practices however interoperability remains an issue. If the hospital and primary care provider use separate EMRs, the benefit is significantly limited. Interoperable electronic health records are viewed as an enabler to effective communication within PCMH model but most systems lack real time consultation functions for maximizing primary/specialty interfaces.

Information and communication technology enabled shared clinical histories between health care providers in a nephrology coordinated care programme between family physicians and nephrologists. The system facilitated rapid and personalised communication through email and videoconferences. A UK study found that an EHR implemented across the primary and secondary care interface supported more integrated care but issues such as access to patient records and duplication of recording in paper systems remained issues. Better use of information technology in general was found to be an enabler to the referral/consultation process in Canada. This is premised on the assumption that physicians have computers in their office and Internet access, which may not be the case. "In Manitoba, a large number of physician offices do not have computers or Internet access. If Internet access is available, it is often only for the clinician, not his or her support staff who are often responsible for tracking down referral contact information." Likewise, the Ontario Medical Association notes that in Ontario, “the use of electronic health records lags behind that of other provinces and countries causing problems for communication between various parts of the system, including between specialists and primary care physicians”.

Approximately 65% of the KIIIs cited the electronic health record as a factor in intraprofessional collaboration. There was a variety of views with half viewing it as an enabler due to the sharing of patient information and the timely and easy generation of discharge and referral letters. The other half felt that it could be an enabler but currently is not due to a number of limitations. One is the interoperability between electronic health records (EHR) and EMRs across health care settings and geographical boundaries. Another is the underutilization of technology such as telehealth in supporting collaboration. Low uptake of the EHR was also identified as a limitation. Patient confidentiality concerns were also mentioned by two KIIIs in terms of shared EMRs.

**Shared Practice Guidelines/Protocols**

Shared protocols/guidelines with common criteria for referrals and shared treatment are deemed to be an enabler to effective collaboration by reducing problems arising at the interface between primary and secondary care. However it is important for consensus to be reached on criteria and roles and responsibilities by all physicians involved. Research on primary care_specialist care linkages in mental health point to care management, enhanced communication, consultation liaison, and local protocols as those linkages most effective. In the study's review of the literature, care management is the coordination of care through a care management plan or defined care pathway; local protocols are an agreed upon process that is structured and documented about a specific patient treatment including evidence based clinical
algorithms. Of all the categories of service linkages reviewed, a service agreement was the only one not associated with any positive outcomes.

One KII saw intraprofessional collaboration grounded on several principles including seeing patients together. The interviewee described a shared care model in which there are shared responsibilities, risks, rewards and accountability. Shared care in psychiatry was cited as an exemplar.

**Lack of Respect**

Sibert et al, found that mutual respect and co-operation are important principles and attitudes for an effective primary care physician – specialist consultation. A lack of respect among physicians was found to be a foundational barrier to effective physician collaboration. Research by Berendsen et al found that specialists do not consider GPs their equals. Specialists admitted to having observed an arrogant attitude among their colleagues towards GPs. This lack of respect for family physicians by other specialty colleagues has been reported in Canada. Research suggests that family physicians are disproportionately exposed to criticism from their colleagues. In fact, it has been found that both medical students and residents have participated in the ‘bashing’ of family medicine. It is believed that negative comments degrading the discipline of family medicine are powerful elements of the hidden curriculum of medical school. The hidden curriculum is defined at a set of peer and educator influences that function within the organizational and cultural structure of the institution. A lack of recognition of mutual expertise was found to be a barrier to effective collaboration in a study of Canadian residency programs. This was in part attributable to a perceived lack of contribution of family physicians educators to the production of scientific medical knowledge. This hypothesis was confirmed by Hojat et al who found that, "as students, primary care physicians displayed less interest in research than their non-primary care peers.”

This lack of respect transcends to specialist to specialist interactions. A study by Stephens et al in the US found that, in fact, while some specialties are targeted more than others, no medical discipline is completely immune from professional badmouthing. They too found that students are commonly exposed to this behaviour. A study of a proactive geriatric consultation found that initially the hospitalists questioned the value of this added specialty consultation service, suggesting a lack of respect for the contribution of the geriatrician.

Seven of the 14 KIIIs acknowledged the lack of respect and appreciation for each other’s contribution and stated it begins in the educational system. Two KIIIs, one of which was a resident, stated the medical educational system is structurally a competitive environment, beginning with competing to gain entry to medical school. This fosters disrespect. Then once in the program you are expected to immediately undergo a mind shift to collegiality. Several KIIIs commented on the silos of residency programs and the need for specialties to learn with each other and to be exposed to each other in their education. Several of the KIIIs spoke of the need for effective role modelling in medical school and residency programs. One resident suggested the structure of medical education in systems blocks promotes the hidden curriculum with specialists providing the bulk of education; generalists are not showcased. This practice transcends to continuing medical education although one KII noted that in BC specialists are no longer teaching family physicians. Two of the KIIIs felt the culture underlying the hidden curriculum is shifting with not so much badmouthing occurring in residency programs. On the other hand, one felt it is worse
than it was 30 years ago, attributing it to an increase in specialization and the number of specialties. It was felt that it is easier to bash doctors you don’t see; badmouthing is a by product of not working with each other. Another KII, a non-family medicine specialist, noted that that it is not only family physicians who experience a lack of respect; it occurs between specialists. There is a hierarchy within the specialties. This KII felt the general lack of respect between physicians is a symptom of a growing physician workload and a sense of entitlement by physicians with a mantra of “I deserve respect”. This sense of self righteousness was echoed by another interviewee who noted that doctors are taught they are special and entitled. In some cases they compete with each other; for example, many non-radiologist specialists think they can read radiological scans.

One of the KIIs, having worked in both urban and rural settings, felt that the disrespect is greater in urban centres than rural areas and is structural in nature. In rural areas, all the physicians need each other which leads to mutual respect. In contrast, there are no structural arrangements in hospitals where both family physicians and other specialists contribute to care. Family physicians for the most part have been moved out of the hospital setting.

Somewhat linked to respect for other physicians is the lack of humility which was raised by three of the KIIs. One of the interviewees described it as a “I know best” attitude by many specialties. Physicians don’t value the view, perspective or second opinion of another physician. Perhaps it shows weakness on their part which is discouraged by the medical profession.

Diversity in the Medical Field

The physician demographic is changing in Canada with an increasing number of physicians from different countries and cultural backgrounds. According to the OMA, “discussions are beginning within the medical community about different cultures having different perceptions and expectations of what constitutes good interpersonal skills, physician-patient relations, and professional and ethical judgement.”

One KII, who is an IMG, noted that there is a bias towards IMGs in both family medicine and other specialties. It was described as an undertone or hidden issue and not unique to Canada, but rather global in nature.

The OMA suggests that a solution to this issue is to build greater cultural awareness within the medical community.

Focus on Primary Care Models of Care Delivery

Increasingly there is a focus on primary health care with new models of primary care being introduced. One example is the Patient-Centred Medical Home (PCMH) in the US. A review of these PCMHs found that until now, the PCMH has focused on primary care physician practices, raising concern from the specialists about whether they have been left out of the discussion. Some specialists have long been recognized as the primary care provider for patients with chronic conditions such as COPD and asthma. Family physicians in these PCMHs have raised concern that they will be held accountable for the activities of the specialists concurrently providing care for their patients. Stange and Ferrer suggest that care needs to be shared or co-managed between primary care physicians and specialists, yet that aspect of the
PCMH has not yet been addressed. Bitton (2011) supports the importance of connectivity to outpatient specialists and acute care, suggesting it is critical to realizing improved quality and efficiency of the PCMH model. This position is echoed by Foy et al who note that the “renewed focus on primary care, however, has not emphasized the potential importance of collaboration between primary care physicians and specialists.”

Canada has experienced a similar growth in the number of structural changes to primary care delivery with family health teams, family health networks, primary care networks, etc. The experience in the US may transcend to that in Canada. No literature was found describing the effect on these models of care on the primary-specialist interface. However, the College of Family Physicians of Canada, in its vision for Canada Family Practice: The Patient’s Medical Home explicitly states that medical specialists should be part of a Patient’s Medical Home (PMH) team or network. They go on to recommend that defined links be established between the PMH and other medical specialists and that these links could be enhanced with formal agreements that include commitments to priority access for their patients. The report highlights the shared care strategies between family physicians and other specialists in mental health as a successful model.

Three of the KIIs commented that primary care models of care delivery are enabling collaboration between family physicians but are pushing other specialists out. Furthermore these models have led to exclusion of family physicians from working in other settings such as emergency departments.

Three of the KIIs, including a family physician, also commented on the isolation and silo effect of family physicians who work in independent practice. This was viewed as a significant barrier to intraprofessional collaboration. Group practices were viewed as a preferred model that support physicians learning from each other and team cohesion. However one physician noted that group practices have a decreased level of accountability with no individual physician ownership of the patients.

**Culture of Blame**

Three of the KIIs identified the culture of blame as a barrier to effective intraprofessional collaboration. One noted that it is this culture which has prevented physicians from sharing patient errors with other physicians. Many physicians are reluctant to refer to other specialists or share care with other physicians for fear of errors being revealed. Two of the three KIIs commented that the new paradigm shift to one of quality improvement is beginning to facilitate better collaboration among physicians in sharing and learning from errors. Two of the KIIs identified legislation requiring the public disclosure of adverse events as a barrier to collaboration; it serves as a reason for doctors not wanting to participate in quality reviews and improvement efforts. The physicians fear they will be blamed for adverse events. One of the KIIs noted that new legislation is being introduced in at least one province to restore confidentiality of quality reviews.

**Patient Centered Care**

One KII offered a very different view of the system issues affecting physician intraprofessional collaboration. This person saw the lack of patient centred care as the fundamental barrier to effective collaboration. The interviewee stated that
changes to system policies and procedures won’t solve the problem; everything is local and it is how they are enacted locally that either promotes or inhibits good collaboration. They described the healthcare system as one set up for doctors and not patients; physicians have been the stewards of the system, not patients. Communication is currently in the hands of doctors and should be in the hands of patients. And there may be communication but no understanding. The lack of an integrated healthcare system across sectors allows anonymity of physicians to contribute to a lack of accountability in the system. The interviewee noted that providing remuneration for consultation does not increase accountability to patients. It was felt that this lack of patient centred care begins in medical school where the smartest, not those most committed to patients, are admitted to the program. The KII suggested that an overall patient centred care framework for all policies and practices is needed, including admission policies to medical schools.

**Success Stories in Canada**

The following are success stories of physician intraprofessional collaboration in Canada and their enabling factors as identified by the KII.

<table>
<thead>
<tr>
<th>Success Story</th>
<th>Enabling Factors</th>
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<tbody>
<tr>
<td>H1N1</td>
<td>• ‘real’ patient need</td>
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<tr>
<td>Cameron inquiry</td>
<td>• Perceived value for their practice and/or patients</td>
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<tr>
<td></td>
<td>• Focus on outcomes</td>
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<tr>
<td>BC Bedline</td>
<td>• Focused on patient and not who the doctor knows</td>
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<td></td>
<td>• Forces a dialogue between the sending and receiving doctor</td>
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<td></td>
<td>• Level playing field between doctors</td>
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<td>UBC curriculum</td>
<td>• More generalist training</td>
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<td></td>
<td>• Broader social responsibilities</td>
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<td></td>
<td>• Interprofessional education</td>
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<tr>
<td>Rationalization of vascular surgery services</td>
<td>• Common goal</td>
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<td></td>
<td>• Facilitated conversation among surgeons</td>
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<td></td>
<td>• Take funding off the table</td>
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<td></td>
<td>• Focus on areas of professional agreement</td>
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<tr>
<td>Cancer centres</td>
<td>• Unified team approach</td>
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<td></td>
<td>• Clear common objectives</td>
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<tr>
<td></td>
<td>• Patient focused</td>
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<tr>
<td>Grand Rounds and M&amp;M Rounds</td>
<td>• Focus on learning, quality improvement and collegiality and not blame</td>
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<tr>
<td>Family Health Teams</td>
<td>• Co-location</td>
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<tr>
<td></td>
<td>• Funding model</td>
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<td></td>
<td>• Non threatening environment</td>
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<td></td>
<td>• Continuous learning environment</td>
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<tr>
<td>Saskatchewan Pediatric School Based Clinic</td>
<td>• Being prepared to think outside the box</td>
</tr>
<tr>
<td></td>
<td>• Specialists come to primary care</td>
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### Professional Development Initiatives Targeted at Physician Intraprofessional Collaboration

The following is an inventory of continuing medical education initiatives/events targeted at physician intraprofessional collaboration identified by the KIIIs. There was a divergent view among the interviewees as to whether pure social events served to improve physician relationships. Thirty percent said they were nice but not effective.

- Provincial medical association social events
- Talks by specialists on what they are looking for in referrals
- Conferences i.e. Family Medicine Forum
- Journal articles focused on collaborative models of care and social issues
- Journal clubs
- Practice Based Small Group Learning hosted by Foundation for Medical Practice in Ontario
- Social networking opportunities over coffee

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<tr>
<th>clinics</th>
<th>Divisions of Family Practice in BC</th>
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<tr>
<td></td>
<td>Geographically based</td>
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<td></td>
<td>Clear objectives</td>
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<td></td>
<td>Priority setting exercises</td>
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<td></td>
<td>Address population health needs</td>
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<tr>
<th>clinics</th>
<th>‘Bridging the Gap’ in Ontario hospital</th>
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<td></td>
<td>Hospitalists call the family physician instead of just sending discharge letter</td>
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<td></td>
<td>Dedicated time booked for telephone consultations</td>
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<td>Remuneration for telephone consultations</td>
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<tr>
<th>clinics</th>
<th>Centralized electronic referral repository in Saskatchewan and Eastern Health</th>
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<tr>
<td></td>
<td>Includes triage component and not necessarily done by physician</td>
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<td></td>
<td>Administrative staff perform quality assurance on referral form immediately</td>
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<td></td>
<td>Standardized referral form developed jointly by family physicians and other specialists</td>
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<td></td>
<td>No need for different referral form for each specialist</td>
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<tr>
<th>clinics</th>
<th>Family medicine ‘Triple C Curriculum’</th>
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<td></td>
<td>New intraprofessional approach</td>
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<tr>
<th>clinics</th>
<th>Rapid Access to Consultative Expertise (RACE) in Vancouver Coastal Health region in British Columbia</th>
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<td></td>
<td>Timely</td>
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<td></td>
<td>Single number to access</td>
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<td></td>
<td>Don’t need to know specialists</td>
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<td></td>
<td>Guaranteed access</td>
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<td></td>
<td>Specialists receive remuneration</td>
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<td>GPs receive .25 CME credit per call</td>
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<th>clinics</th>
<th>‘1 # System’ in London</th>
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<tr>
<td></td>
<td>Forces dialogue between referring and accepting doctors</td>
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<td></td>
<td>Timely</td>
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Physician Management Institute
CMA modules
Canadian Society of Physician Executives leadership training
Educational program for physician leaders at Western Health

Summary

A review of the literature and key informant interviews revealed a number of system’s issues, policies and practices enabling or hindering physician intraprofessional collaboration. These include:

- Remuneration
- Liability
- Role clarity
- Differing cultures
- Workload/time
- Wait times
- Communication
- Shared practice guidelines/protocols
- Lack of respect
- Diversity in the medical field
- Focus on primary care models
- Culture of blame
- Patient centredness

Many of these are linked such as workload/time and wait times, culture of blame and liability, and shared practice guidelines/protocols and role clarity. In most cases, the interviews validated the literature. There were a few exceptions such as liability which emerged in the literature, but not much in the interviews. Three emerged from the interviews which were not predominant in the literature: culture of blame, patient centredness and diversity in the medical field.

Physicians identified a number of success stories across Canada although a few physicians could not identify one. Interestingly a number of interviewees identified success stories from British Columbia even though they were not from there. Perhaps that province is leading the way in promoting effective physician intraprofessional collaboration. Further analysis of these successes could lead to their replication across the country.

Approximately the same number of continuing medical education initiatives/events that foster such collaboration were identified by the interviewees. Several of them could not identify any such initiatives. Those who did put forth initiatives often identified multiple examples. Several KIIIs identified the same ones: the Physician Management Institute and journal clubs.
Appendix A

Physician Intraprofessionalism

Interview Guide

Thank you for taking the time to participate in this interview. It is expected the interview will last approximately 30 minutes. All responses will be kept anonymous.

At the beginning you will be asked your specialty and practice setting. The interview will then focus on the following questions:

1. What do you see as the system issues, policies and practices that facilitate effective physician intraprofessional collaboration? (i.e. funding models, electronic health record, etc)

2. What do you see as the system issues, policies and practices that hinder effective physician intraprofessional collaboration? (i.e. lack of common residency education, inadequate referral processes and tools, workload, etc.)

3. Please provide examples of ‘success stories’ and their enabling factors as it relates to physician intraprofessional collaboration in Canada?

4. Are you aware of any professional development initiatives targeted at improving physician intraprofessional collaboration?
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System Issues, Policies and Practices Affecting Physician Intraprofessionalism


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System Issues, Policies and Practices Affecting Physician Intraprofessionalism

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