Putting the principles of collaboration into family practice

Scientists from evolutionary biologists to psychologists have found neural and genetic evidence that we are predisposed to cooperate.[1] History is full of examples of great inventions, works of art, and highly successful businesses born of individuals or groups of people working with others to create or produce something.

The General Practice Services Committee (GPSC) is a collaboration of the BC Medical Association and the BC Ministry of Health. The success of this partnership led the GPSC to establish Divisions of Family Practice in 2008, with the belief that the principles of cooperation and common purpose used by the committee could also be applied to improving primary care at the community level.

Collaboration is the opposite of old school, command-and-control-style management, which is based on a belief that human beings are intrinsically self-interested and uses rewards and punishments to motivate people.

But because it doesn't require complete consensus to reach decisions, collaboration also depends on a formal structure to ensure that conclusions are reached in an efficient manner. In other words, while the projects that a collaborative enterprise works on can be flexible, the expectations and processes must be clearly defined.

Divisions of family practice are collaborative on three levels. First, they give local family physicians, who often work in isolation, the opportunity to network and share ideas. Second, they lay the foundation for division boards of directors to engage with their peers, solicit their opinions about primary care reform, and be their voice with health care partners. Third, through collaborative services committees, they provide a forum for these doctors to work with their regional health authorities and the Ministry of Health to cooperatively discuss issues and implement solutions.

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The roles and responsibilities of each Collaborative Services Committee partner are clearly defined in a formal document of intent, as is the spirit of collaboration, "a commitment to the co-design of potential clinical programs in a way that acknowledges the unique perspective of each partner" (unpublished Divisions of Family Practice Document of Intent).

As Dr Martha Wilson says, "Many of the doctors on our board were skeptical at first. There's long been tension between our communities because of past allocation of health care resources, and a lack of trust of the historic top-down management of the health authority." Dr Wilson is a family physician in Nelson, chair of the Kootenay Boundary Division, and co-chair of its Collaborative Services Committee. "But they respect the work of the GPSC, and when they recognized that divisions are intentionally modeled on the same principles of collaboration and consensus that the GPSC uses, they were inspired to consider this new model."

The number of divisions established to date, and the progress they are making, would indicate that the GPSC got it right.

Just 10 years ago, the health care system was characterized by top-down management. Doctors felt undervalued, disconnected from their peers, and professionally dissatisfied. Health authorities too were dealing with less than ideal circumstances. The quality and availability of primary care was declining, yet there was no infrastructure for working with family physicians broadly across a community to implement solutions.

Divisions are addressing these problems for both parties. Dr Wilson says that while the Kootenay Boundary Collaborative Services Committee has not yet selected a joint project, "We're delighted to discover that our divisions and the health authority view things like integration of health services in a similar light. Our members have ideas for shared care with specialists that could work in other rural communities, which we've proposed to our Collaborative Services Committee. And we're recognizing the huge power of doctors from all parts of our region collaborating to solve the problem of a single small community, like Kaslo."

Diane Miller, executive director, Primary Health Care and Aboriginal Health with Fraser Health Authority, says progress is being made because each partner is making an effort to understand the other's perspective. "Family physicians are telling us their concerns in relation to the health of the population in their communities, and what they see as barriers to providing good care. And they're asking

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every several months may help to optimize therapy and reduce toxic events.

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—Roy Purssell, MD, FRCPC, ABEM Medical Director, BC DPIC
—Michael Copland, MD, FRCPC, Medical Director, Kidney Services, Vancouver Coastal Health

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us what our priorities are. As we listen to one another and the trust develops, we're finding out that quite often our priorities are the same."

Dr Ken Burns, a long-time family physician with a full-service practice in Maple Ridge and physician lead of Ridge Meadows Division of Family Practice, says the Division has turned things around for him and his colleagues. "Things have improved on a number of levels," he says. "We've regained the collegial rapport among doctors in the community. We've also formed relationships with people from Fraser Health and the ministry, and because they're sitting across the table from us, they're not 'those people from Victoria' anymore. We all realize that we have much in common, and on this basis we can move forward on projects that will do so much good in our community because there's trust and people are willing to pitch in and help one another."

For more tips about collaborative decision making, please visit the Divisions BC website at www.divisionsbc.ca/provincial/collaboration.

—Brian Evoy, PhD
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Reference

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