RESTORING PRIMARY CARE

REFRAMING RELATIONSHIPS AND REDESIGNING PRACTICE

ANTON J KUZEL AND JOHN D ENGEL

FOREWORD BY
DAVID LOXTERKAMP

AFTERWORD BY
WILLIAM L MILLER

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The authors dedicate this book to their wives,
Linda and Deborah, to the patients whose stories
motivate us to work to improve primary care, and
to the colleagues who inspire our hope
and provide a way forward.

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ANTON J KUZEL
MD, MHPE
Department of Family Medicine
Virginia Commonwealth University

and

JOHN D ENGEL
PhD
Institute for Professionalism Inquiry
Summa Health System
Department of Behavioral Sciences
Northeastern Ohio Universities College of Medicine

Foreword by
DAVID LOXTERKAMP
MD

Afterword by
WILLIAM L MILLER
MD, MA

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Foreword

THE REFLECTIVE PRACTITIONER AND THE GOALS OF MEDICINE

When Tony Kuzel and John Engel asked me to write the Foreword to their book, they suggested that I "speak to what is needed to reinvigorate primary care from the perspective of the reflective practitioner." It had been almost 20 years since I first heard that phrase, while on sabbatical at the University of California, San Francisco, and its memory excited me. The reformation of primary care is often seen as a systems problem—how to get payers to pay for it, students to study it, and coordinated teams to tackle it. Little attention is afforded to the select few professionals who can actually steer us there. I am not talking about visionaries, educators, or policy-makers, but primary care leaders in patient care. What motivates them? What discourages them? What prepares them for the hard but gratifying work of shared leadership? What keeps them from burning out?

In their book, Drs Kuzel and Engel offer a clear, practical, and evidence-based guide for the transformation of primary care practice. It is intended for those unwilling to sit on their hands until the conditions are right. Their program, like many, will achieve the end product of an NCQA (National Committee for Quality Assurance) certified patient-centered medical house. But they are reaching for something more. They challenge us to make it a home and to think carefully about who will live there.

Let me begin the conversation. First, I'll describe my own experience with home construction over the last quarter century. Next, I'll revisit Donald Schon's classic text, *The Reflective Practitioner: how professionals think in action*.[1] And lastly, I'll talk about leadership and its elusive shadow, offering another way to consider vision, strength, and the goals of medicine.

In January of 2010, my practice joined the Maine Patient Centered Medical Home Pilot. Over the next three years, we expect to receive a monthly payment for every patient who is an active enrollee in the state Medicaid program plus

three private insurance companies. The 10% boost in annual revenues will allow us to experiment with office reconfiguration, the addition of ancillary staff, and an opportunity to participate in a network of physicians and practices who are enthusiastically embracing practice reform. It has taken us 25 years to get to this point. Milestones include:

1992 Becoming a rural health center
1994 Choosing our first electronic medical record (EMR) system
2004 Prescribing Suboxone for opioid addicts
2005 Building a new office
2006 Implementing our second EMR; beginning the National Demonstration Project
2007 Offering a patient portal
2008 Adjusting to open scheduling
2009 Recruiting two young family physicians and a physician's assistant.

Inexplicably, one step leads to another. Becoming a rural health center doubled our salaries overnight, largely by paying us for the cost of treating Medicaid patients. Our first electronic medical record taught us what to look for in the next. Office-based treatment of opioid dependence provided our first exposure to population management, mental health care, and working with a systems approach. The National Demonstration Project nudged us to make two simple changes in our practice that dramatically transformed it: open scheduling (which allows same-day access to the provider) and a patient portal (which allows instant access to the entire medical record and greater accountability, partnering, and email communication). Finally, successful recruitment has given us hope for the future, the ability to extend office hours, and the opportunity to build the kind of practice we always imagined.

In their "Ten steps to a patient-centered medical home" (Chapter 6), Kuzel and Engel are squarely on target. They describe the key interlocking pieces of a congruent whole, the assembly of which takes imagination, perseverance, and bit of luck.

In 1984, my wife and I moved to Belfast, Maine. Shortly thereafter, I formed a partnership with Tim Hughes, a family doctor who shared my sense of humor, love of stories, and practice philosophy. But six years of caring for the infirm, pregnant, critically ill, homebound, poor and marginalized took their toll. We both needed a break. While I "held the fort," Tim spent a year in Costa Rica establishing a new family medicine residency program; I left the following year for the West Coast.

It was around this time that men with AIDS were returning to Waldo County, often to reconcile with their families, always to die. HIV was unknown during my residency, and in the first years of practice it was barely understood or adequately treated. As I looked around for fellowship sites, San Francisco seemed a logical location. I was accepted at the Family and Community Medicine Fellowship Program at San Francisco General Hospital, then directed by Dr Peter Sommers. It was during his seminars that we read Donald Schon's groundbreaking work. I felt then, and still believe, that this professor of urban studies and education at Massachusetts Institute of Technology (MIT) thoroughly understood how accomplished family physicians worked, and where the discipline must lead the transformation of primary care.

In his book, Schon was critical of what he saw as the dominant pattern of professional thinking, something he called *technical rationality*. In this mindset, practice is a problem-solving activity undertaken by professionals who alone decide which problems are appropriate, how they should be treated, and what to do with conflicting data. When raw data does not conform to the canon of fixable problems, the expert discards it. And where people are at "fault," they are labeled as outliers, malingerers, or neurotics.

Schon agreed that emergencies and routines require a precise and methodical approach. But he was more interested in the moment before action, when professionals frame their experience as recognizable problems, or later, when these problems do not respond in the expected way. He described *reflection-in-action* as the ability of a professional to adjust to surprise, frustration, or failure, and to make corrections in understanding or technique while the outcome is still in question.[1] The work of primary care always begins by "setting" or framing the problem. Is it a medical problem? Does the patient want or need it fixed? Is treatment failure the result of a misdiagnosis, the need for more time, or an incomplete grasp of the setting?

For Schon, the reflective practitioner was someone who welcomed surprise. Reward came not from achieving a certain level of proficiency in treating familiar problems, but from a sense of discovery in the strangeness, instability, uncertainty, and conflicting values of the problem at hand. Rather than working safely in pre-existing categories, he joined the patient in a shared, intuitive, and largely creative process. The setting for that process was a relationship where the doctor focuses on the quality of a life, using his own as a reference point.

The reflective practitioner "gives up the rewards of unquestioned authority, the freedom to practice without challenge to his competence, the comfort of relative invulnerability, the gratifications of deference. The new satisfactions open to

him are largely those of discovery—about the meanings of his advice to clients, about his knowledge-in-practice, and about himself."[1]

Kurt, a 24-year-old on state assistance, is enrolled in our office-based treatment program for opioid dependence. He faithfully sees an addiction counselor every week and a medical provider every other week. His daily dose of Suboxone (which contains buprenorphine, a partial opioid agonist) is only 8 mg a day. He smokes cigarettes, but doesn't drink alcohol, and his urine drug screens have always been "clean." Kurt also takes medication and receives a disability pension for Bipolar disease.

Though he has been coming to the office for six months, this is only the second time we've met. I learn that he is neither employed nor in school. He dropped out of high school and expresses no interest in earning a GED. He currently lives with his father and watches television in his room all day. He has a girlfriend who works two seasonal jobs for minimum wage. And though they have lived together for the past four years, he has no plans to marry or have children.

He returns today for a refill of his Suboxone and to discuss smoking cessation. At last visit, he set a quit date and began wearing a nicotine patch. But after three days, he resumed smoking, stating that it was "just too hard."

> "What are you willing to work on?" I inquire.
> Kurt turns with a puzzled look. "Nothing, I guess. I'm just lazy, and always have been."

I am curious, annoyed, and baffled by his lack of spark, but also by his honesty. He tells me that he and his therapist mostly watch videos about addiction. They do not discuss "plans," a topic that troubles him, he admits, largely because it troubles his father and girlfriend.

So what is the doctor to do? Am I "treating" his addiction or "enabling" his laziness and indecision—or both? Should I continue to prescribe Suboxone because it is working? Should he stay in counseling because he attends it regularly? Should I urge him to see a therapist who will challenge his self-diagnosis of laziness, or offer a psychiatric referral to revisit his label of Bipolar disease? Should I taper him off Suboxone if he is unwilling to work on anything in life, or continue it because he has chronic opioid dependence (which, of course, my prescription maintains)?

By asking, "Is laziness a problem?" have I over-reached my professional bounds or imposed my own values? Is it equally lazy—even unethical—for

health professionals to ignore the biopsychosocial determinants of disease and maintain our patients in dependent relationships? What are the goals of medicine?

This is the question increasingly asked as our focus becomes patient-centered. Because primary care physicians (PCPs) form relationships with their patients, certain questions are obvious and relevant: "Why is the patient here today? What is the source of his unhappiness? Can I help him identify or resolve it, whatever it is?"

The proponents of motivational interviewing (MI)—first described by William Miller and Stephen Rollnick—encourage and prepare us to be catalysts for change in the troubled lives of our patients. They emphasize that MI is less "technique" than conversation, more an invitation for the patient to work through his ambivalence than a contest for change.[2] The patient's readiness matters, but so does the doctor's demonstrated investment and confidence in the patient's future.

Having passed a quarter-century of caring for patients, I am aware and confident of my habits in the exam room. The most effective are these:

- Let patients know you are glad to see them.
- Meet their eyes, as it expresses your concern and reveals what words cannot.
- Touch them, especially where they are diseased. This is the physical expression of our intent to provide a sense of connection and approval.
- Only give advice that addresses their goals.
- And make sure they understand what is wrong, when they'll be better, and what to do if they're not.

John Scott and others have described healing environments or settings that rely upon the sensitivity, skill, and contribution of each member. Almost 30 years ago, Schon provided his own vision of such a place:

> A reflective institution must place a high priority on flexible procedures, differentiated responses, qualitative appreciation of complex processes, and decentralized responsibility for judgment and action. In contrast to the normal bureaucratic emphasis on technical rationality, a reflective institution must make a place for attention to conflicting values and purposes.[1]

In the section, "Essentials for the journey" from Chapter 6, Kuzel and Engel also focus on the health care team. They ask why certain teams—and the practices they serve—work better than others. Borrowing from Tony Ghaye and his book, *Developing the Reflective Healthcare Team*, they look to the qualities of team

members. Leaders emerge who exhibit a kind of "quiet leadership" that seeks to change their own behavior before requiring it of others; fosters a culture of questioning and problem solving; puts team goals before personal agenda; allows decisions to be made at the level where they most directly applied; and cultivates an "emotional awareness" that informs decision making.[3] This kind of leadership is seen less easily in the attributes of a single provider than through the influence cast upon the team and its goals.

In our experience with practice innovation, curiosity has always been the driving force, pushing us to weigh, compare, question, and challenge our current practices against the deficiencies we live with and toward an elusive "ideal." Curiosity is tempered by the need for tolerance, understanding that not everyone may need to change, or change to the same degree, or change at the same pace. Humility reminds us of our limitations and the need for others' insights. Transparency is a sign of self-confidence; it promotes mutual respect and a sense of inclusion. We have come to regard change itself as a positive value, preferring it to the familiar, easy, and predictable. Lastly, struggle to place greater value on relationships than the "bottom line," knowing how easily the sense of human connection can be pinched by the pressures of efficiency, quantification, and financial reward.

I am not sure that my practice succeeds as a reflective or healing environment. Such attention takes time. It distracts from the business at hand. It leads to disappointing results based on conventional measures of quality. It requires hard work and commands an ever higher bar. But it is, I believe, what our patients need and deserve as we engage them in extended, committed relationships, remaining curious and questioning about the causes of illness and means to health. There are others who can apply protocols more consistently, automatically, and routinely than a family doctor, including computers and technicians. This is not where our skills are required. Rather, it seems to me, our role lies in uncovering the unique elements inside a patient's concern, at this moment in time, impeding their pursuit of health as they define it.

Why don't more doctors improve the health of their practices? Why can't we make them responsive, effective, and joyous places to work? What Ira Glass, host of National Public Radio's *This American Life,* recently said about writing applies equally to the practice of medicine: "It's like a law of nature, a law of aerodynamics, that anything that's written or anything that's created wants to be mediocre. The natural state of all writing is mediocrity. It's all tending toward mediocrity in the same way that all atoms are sort of dissipating out toward the expanse of the universe. [. . .] So what it takes to make anything more than mediocre is such an act of will."[4] That act requires a spark, something that needs fuel to flame

and friendship to spread and shelter it. Good medicine requires our attention to deeply buried needs and injuries. It is simple and universal and achievable in every encounter. By offering it to others, it is returned to us in full. It is the work of the reflective practitioner, the yeast of a healing environment, and the fundamental goal of all medicine. It stems from the awareness that the doctor and patient share a similar need: to take responsibility for their own happiness. The most satisfying and effective way to learn this is through a nurturing relationship wherein what the doctor offers—often, all we offer—is conversation, friendship, and hope.

David Loxterkamp, MD
Belfast, Maine
September 2010

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Preface

This book represents a connecting of dots—linking prior studies we and others have done on patient safety with the current movement on practice redesign in primary care. As we reflected on the avoidable problems and harms in the primary care experiences of patients in Virginia and Ohio with whom we spoke several years ago, we realized that many of the primary care redesign strategies (advocated most notably by the Institute for Healthcare Improvement) would directly address those problems and likely lead to safer, more effective care for patients. They would also foster a relationship-centered primary care environment that, in our view, is the real point of the so-called patient-centered medical home.

We are also alarmed by the enormous shift away from primary care in the US that has occurred over the past 15–20 years, which is due in part to cultural factors in the US and in the places where most doctors train, but mostly due to the bizarre way in which care is financed (and therefore incentivized) in the US. There is no systematic push to improve the health of patients or populations, but rather enormous incentives to perform tests and treatments on people, often with little or no evidence of benefit. We hear and support the calls for reforming the financing of health care in the US so as to reduce or eliminate the perverse incentives, but the recently passed health care reform act, while admittedly the most significant change in health care policy in the US since the establishment of Medicare and Medicaid in 1965, does little to change incentives (except through pilot projects). While it provides new coverage for about 30 million US citizens, it doesn't do much to also ensure that they will have access to primary health care.

The reason for this partial achievement is, in our view, because a system that focused on population care and that is based in primary care would create dramatic shifts in funding away from the entities and individuals who now profit greatly from the current arrangements. Knowing that it will likely be 10 or 20 years before the rest of reform is passed (the politics are daunting), we feel a sense of urgency to help create change *now*, and we look for strategies to