Sharing or shuffling — realities of chronic disease care in general practice

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TO THE EDITOR: We conducted a qualitative study to explore the perspectives of general practitioners and allied and other health professionals on their interactions in the care of patients with chronic disease, especially where Team Care Arrangements (TCAs) are involved. We interviewed 16 clinicians from urban and rural New South Wales who were involved in the care of patients with type 2 diabetes, ischaemic heart disease and hypertension — four GPs, two practice nurses, two medical specialists and eight allied health clinicians. Interviews took place from late 2006 to early 2007.

While all those interviewed felt that a coordinated approach provided optimal management of chronic disease, this did not always seem to translate into smooth working relationships. Allied health clinicians and medical specialists described two types of attitudes of GPs to team care. They perceived some GPs as accepting of the involvement of others in patient care, leading to mutually respectful and highly satisfying working relationships. However, they felt other GPs did not value the opinions of allied health professionals and referred patients to them to fulfil a process (either for TCAs or at the patient's request), or saw them as competitors. As one urban allied health clinician said, "I think they've got to realise that we're not there to compete, we are there to assist".

TCAs provide financial incentives for GPs to coordinate care.[1] We have previously reported that multidisciplinary care plans are associated with improved attendance at allied health services and improved metabolic control for patients with diabetes.[2] However, in the present study some respondents felt that TCAs were little more than "paper shuffling" — predominantly a mechanism to attract reimbursement, rather than to facilitate two-way communication. Although TCAs provide an opportunity for communication between health care professionals, they have not overcome all the barriers to communication, especially in cases where an interprofessional relationship based on clear understanding of each other's roles has not already been established.

Our findings suggest that relationship-building and discussions about roles in shared care, including the power differentials between professionals, would improve the functioning of TCAs. Other recent studies have also reported on the lack of effective collaboration between GPs and other health professionals in managing chronic conditions.[2,3] Respondents felt that it was uncommon for clinicians to discuss and agree on a plan of care.

Optimal management of chronic disease requires a team approach and, consistent with other studies,[4,5] we found that all the professional groups interviewed acknowledge the desirability of team care and its potential to improve patient outcomes. With increasing emphasis on team care, it is imperative that policies fund and facilitate a real team approach that is in the best interests of patients — one that places greater emphasis on two-way communication rather than paper shuffling or gatekeeping. This requires working with allied health professionals, medical specialists and GPs to improve communication and trust between clinicians. The Divisions of General Practice must surely be well placed to facilitate this process.

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1 Australian Government Department of Health and Ageing. Enhanced Primary Care Program: chronic disease management Medicare items. http://www.health.gov.au/internet/main/publishing.nsf/Content/pcd-programs-epc-chronicdisease.htm (accessed May 2008).

2 Zwar NA, Hermiz O, Comino EJ, et al. Do multidisciplinary care plans result in better care for type 2 diabetes? *Aust Fam Physician* 2007; 36: 85-89.

3 Shortus TD, McKenzie SH, Kemp LA, et al. Multidisciplinary care plans for diabetes: how are they used? *Med J Aust* 2007; 187: 78-81.

4 Wagner E. Chronic disease management: what will it take to improve care for chronic illness? *Eff Clin Pract* 1998; 1: 2-4.

5 Wagner EH. The role of patient care teams in chronic disease management. *BMJ* 2000; 320: 569-572. ❑