10 - pbb E10 My work depends on the setting

Mon, 5/9 1:36PM • 30:07

SUMMARY KEYWORDS

setting, medication, suppose, people, patients, work, health, doctor, tasks, interaction, person, sleep, prescribing, practice, john brennan, conversation, prescription, paul, sense, built

SPEAKERS

Madge Kaplan, Paul Batalden, John Brennan

Madge Kaplan 00:00
Welcome to The Power of Coproduction, a podcast series that explores the lived experiences of patients and professionals who are redesigning healthcare service to achieve better health through mutual respect, collaboration and science informed practices. Your host and guide is Paul Batalden, Professor Emeritus of the Dartmouth Institute for Health Policy and Clinical Practice and a guest Professor Jönköping Academy. The Power of Coproduction is produced in partnership with the International Coproduction of Health Network (ICoHN), the Dartmouth Institute, Jönköping Academy and the Health Assessment Lab. On Episode 10, “My Work Depends on the Setting,” John Brennan shares the way his work settings influence his medical practice. Here's Paul,

Paul Batalden 00:50
Welcome. We continue our exploration of the various streams of knowledge, skill and habit that inform the coproduction of a healthcare service. Today we're exploring the lived reality of the person we sometimes know in the role as a health professional. Dr. John Brennan of Ireland is a family physician, he has worked in different settings, and reflects on the ways in which those settings made it easier or harder for him to do his work. He will help us explore the ways that the lived reality of the health professional person matters to the work that they are able to perform. Thank you so much for being with us and welcome, John.

John Brennan 01:39
Thank you, Paul. It's great to be here.

Paul Batalden 01:41
You've worked in different settings as a doctor. And as you think of those settings and work experiences, were they all the same?

John Brennan 01:49
No, well, I can't say that they have been. I qualified as a doctor 10 years ago now. And in that 10 years, I've worked across a huge variety of different settings, both in hospital-based care and in the

community and several different countries in training posts, and then more latterly as a practicing general practitioner, family doctor. And every setting that I've worked in has been different in some way or another. And there's a huge variety out there.

Paul Batalden 02:16
Is there a story that would help us understand a time when it was either easier or harder to do your work?

John Brennan 02:24
One particular story springs to mind for me. A couple of years ago now, I was working in a practice in my office running through or working through some repeat prescription requests. So, requests that patients had put in for refills of medication. I came across a request for medication for sleep, a sleeping tablet for a lady. I had a look at her file or her chart: she'd been on this medication for five years. And in that five years, it didn't look like there had been too many conversations to check in on how she was doing on that medication , or what the purpose of the medication was and whether it was meeting her needs. So I asked our team at reception to contact her to book an appointment to come to see me so that we could check in on the medication and see if anything needed to be adjusted. I suppose in the background working in Ireland, I'm aware that in Ireland, we have an issue where we prescribe probably too many sedative type medications or sleeping tablets to patients. So one of our roles as doctors obviously is to make sure that we're prescribing appropriately and safely, particularly medications like that, that can carry harm. So you know, I felt it was quite important that she would come in, and we'd have a review of this medication. And the reception team contacted her and she booked an appointment to come in and see me the following week. So when her name appeared on my list the following week, I went out to the waiting room to call her and bring her down to my room. I noticed straight away I suppose, as soon as she came through the door of the consultation room, that you know, something was up maybe she wasn't so happy to be there with me. She hardly made eye contact as she came in, she sat straight down before I could invite her to take off her jacket or welcome her or connect in any sense. And before I could even open the conversation, she said I'm just here for my sleeping tablet, full stop. You know, I tried to work back a little bit and you know, maybe comment on the weather and try and make her feel a little bit more relaxed and a little bit more welcomed. But I was getting one word answers. And I suppose it was clear to me that she was not there to have a discussion necessarily with me. She was there for a transaction. This is what you do Doc, you sign the prescription or you send/email the prescription and then I leave again. And I tried in several different ways to open conversations about her and her life and her sleep to figure out if you know if there was something better we could be doing with her for her health, but to absolutely no avail. And after three or four attempts, she brusquely said, “Are you going to prescribe this medication or not?” An ultimatum, yeah. And I mean, it was one of those interactions where you could sort of feel the heat, you know, as it was bubbling or building more into kind of an argument or a confrontation than a consultation. I'd never met this woman, you know, in person before. It wasn't like we had a history of disagreeing on anything in the past or that she had been a patient of this practice in this setting for a period of time, when I again said, “Well, there are certain things we need to talk about to make sure that we're not inadvertently harming you with this medication.” First, she stood up, and she stormed out of the room. I was, I suppose, left sitting there at my desk, you know, with that sort of hollow, almost nauseous feeling that you can get after you've been in a confrontation like that. And it was a pretty lonely place to be

because in this setting, I suppose, it was the type of practice with multiple doctors and nurses working in multiple rooms, but the doors were more often closed than open. And I did, you know, later that day, or at the end of the day, try to open a conversation with a colleague, you know, about this interaction in case she came back to make a complaint or, or whatever else, but their response was a shrug of the shoulders and, and “these things happen.” That was it.

Paul Batalden 06:07
She had been a patient there before, she knew the way things worked, and the way things worked were not the ways in which you were following. And there was this tension between her expectation about the way things usually worked, and the way you were working. And what you were trying to do was to do your best with respect to the renewal of the prescription and the safety of the medication and so on. I'm curious about the role that the other members of staff played, in addition to the one that you talked to. Was it, did she check in with somebody? And any other person, any other role, help open up the time in the clinic with her in some way, or welcome her or something like that?

John Brennan 06:54
The routine would be that she would come to the reception desk on arriving in the building and check in and they'd ask her to take a seat in an area that they could see or watch. And they'd be aware, I suppose, if patients were there and waiting a period of time to be seen, and that sort of thing, but the culture wasn't that there would be a chit chat or anything like that. And in that interaction, and I suppose, you know, the staff at the desk would have been aware that she would have left very quickly, without saying goodbye, you know, there would have been an awareness of that, but no conversation, I suppose, would have happened around “Is everything okay?” Or coming back to me to see if anything could have changed or have been done differently. So I suppose it was, you know, a much more kind of transactional sort of mindset, or setting people in their silos, doing just what's in front of them. And that was very much the feel, and the culture of the place. You know, it was all about kind of throughput, making sure that targets were hit on the number of people that were seen, in a given space of time, how that generates, you know, work and income for the practice and that sort of thing. And I suppose one of the saddest things about the story, which I only subsequently became aware of two weeks later, was that she came back then to see a different doctor in the practice, and had one of those two minute interactions where the prescription was written or signed, and she left.

Paul Batalden 08:18
So that was a setting that didn't really make it easy for you to do your best. In fact, it was kind of a tension or struggle to do your best. Is there another story that would help us understand a different kind of environment?

John Brennan 08:33
I suppose if you take my current work setting, you know, again, working through prescription refill requests a number of weeks ago, a prescription came across my desk for one of these sleeping tablets, in a man that I know, you know, a little bit better. A man who's had a major gastrointestinal surgery about 12 months ago, and I noticed that this medication had appeared on his list since that time. So again, in a similar way, recognizing that it's a high risk medication, and there are aspects to not just, I suppose, safety for the medication, but also, when someone's requesting a medication like that, on

repeat, it can often be indicative of something else that's happening that means they're not sleeping or whatever. So I asked our reception team to contact him and asked if he would come to see me for a conversation about this medication. So they contacted him and he booked in. His name appeared on my list in a similar way. But unlike the circumstance before, before I even had a chance to call him from the waiting room, a receptionist knocked on my door and said, he's here to see you and he doesn't seem himself today. So you know, just be ready for that. So again, I called him up from the waiting room. And again, I could tell as soon as he walked through the door that he wasn't making the same sort of eye contact that he usually would. It was almost like he was worried about something, as opposed to being angry, annoyed or affronted. He sat down, and we were able to open a conversation around, I suppose, what he was most worried about, or what he was most concerned about. I asked, “Do you know why we've asked you to come in today?" He said, “I'm pretty sure it's about this sleeping table;, please don't take that away from me.” So, immediately this sense that doctor, you have all the power, and I'm worried, I suppose, that you're going to exert that power, and I'm going to be worse off as a result.

So we got into a conversation about why it was that that sleeping tablet felt or seemed so important to him. He had been started on it after a complicated course in hospital, he'd been in hospital for six weeks at the time. And as we all know, hospitals are not easy places to sleep, you're on someone else's schedule all of the time, and a hospital doctor in trying to help had started this tablet or medication. But by the time he left the hospital, he found when he got home, he couldn't sleep without it. Now, subsequently, he's made a good recovery. And he's back to work. And he told me what he was most worried about. As a taxi driver, it was that if he didn't get a good night's sleep the night before, he'd be worried that he could harm someone else on the road the following day. When we talked though a little bit more about, you know, other factors affecting his sleep different things that were going on in his life, worries about his health, more generally, what had happened and supporting his family. And also then some of the physiological and pharmacological realities of these medications and how they work, how they can actually make someone more impaired in a role like he's doing despite sleeping for longer that was a big eye opener for him. We were working more around, I suppose, what he was able to tell me was most important in his life, where the concerns were coming from. And we worked through a plan that meant he was able to think about stopping slowly and reducing this medication, with the goal of actually having better sleep, after that, feeling safer on the road. And also a plan around working through some of those issues, that he was most concerned about, other aspects of his health, and worry more generally, for him, because that was greatly affecting him. So it was a very different conversation, a very different interaction.eWe were leaving that discussion with a shared plan about what might help his health more generally. And I'm delighted to report that a couple of weeks later, he's ditched these medications completely and feels great. He didn't realize I suppose what sort of a drag they were having on him. And once he was able to break the cycle of his body being so used to these medications and get out of that, that window of his body, associating a dose of this medication with commencing sleep, he's now sleeping better and for longer, but most importantly, waking up far more refreshed, and more able, generally, to kind of work through the different issues that also kind of concern and worry him. So you know, we have an ongoing interaction now around different aspects of his health. But this is a shared win for us. And another step in creating that trust, that helps us build better health. So you know, worlds apart, in a sense, but the setting and the culture of the place has

played a huge part in how those different interactions have played out, and what we've been able to achieve.

Paul Batalden 13:37
You have a sense that in the first setting, the system was not really designed to get the real work done. And in the second setting, the system and the real work fit each other much better.

John Brennan 13:52
Absolutely. I mean, setting one is very superficially, through a very kind of medical transactional model, claiming to provide care, but it's very superficial. Setting two then, is set up much more so to make sure, I suppose, that we reached the heart of the issue. And our lens is much broader in where we look, so that we can provide value and work with people to optimize health. And that starts you know, as you say, from even before the front door. Both practices are providing longitudinal, primary health care, but in profoundly different ways. Likewise, you know, in the background behind this with this set of medication issues, setting one, it's ignored. Conversations when you start to try to open them about prescribing rates and that sort of thing are shut down. This is just the way things are. Setting two conversations happen in the background where a problem is identified, people are curious, they want to know, the doors are open. When people talk about what constitutes good care, but more importantly, how we can get better all of the time, how we can learn together, and how we can work with people and alongside the people we provide care to, to continuously improve how we can reframe these different issues, because there were no harms envisaged when people started prescribing these medications, whenever that happens. So it's an extremely dynamic situation and environment to be in, in setting two it's reassuring, though, that everyone is is looking at that together, and the brain power is shared and the will is shared, the problems are shared, and the solutions are built together,

Paul Batalden 15:41
You have the sense, at least I have the sense, that the person in setting two who popped in before the patient was brought into the room could see the effect of the transition from before the visit to after the visit, and must have felt like she had contributed in some way to that transformation.

John Brennan 16:02
Absolutely. The team is not just the clinical team; the staff that work on the front desk in setting two, are constantly feeling and sensing in the environment out there. Primary care is a very uncontrolled setting or place compared to an intensive care unit, for example. So we need, you know, sensitive sort of feelers out there, in terms of what's going on, if people are contacting you remotely from home, or even what the latest concern in the community might be. a road traffic accident has happened or someone has tragically died, or around where we work, sometimes it's a farming accident. It's our front of house staff who usually know about that first, and are filling in those gaps between us and our patients all the time. So that we're thinking and feeling from a shared sense of community, it's a far more cohesive way to work.

Paul Batalden 16:57
Those are two very powerful examples of the difference that a setting may contribute to getting the work done. And my sense is that your own experience of working in setting one and then setting two

probably was different at the end of a day. There might be a sense of accomplishment that was more commonly experienced in setting two than in setting one. And I may be wrong about that, but my sense is that going to work might even feel different in setting one and setting two,

John Brennan 17:34
It absolutely does. In both of those settings, for example, the rate of pay can be the same, or has been the same. You can check in and check out. In setting one though, it's like you're paid, (kind of you know,) by the hour, per transaction. Setting two it's like you're on a salary to add all the value you can in that window or in that space. The other really interesting thing that happens between those two settings: in setting one, if a patient has to wait longer than a few minutes to see the doctor, there are complaints, people are getting annoyed, stress levels are rising. In setting two, if someone has to wait longer, when you bring them in and say I'm very sorry about the delay, usually the response is "Doctor, I completely understand, and I know if I needed the time you'd give that to me too." So you have a sense that the patients who come to see you are donating time to one another too and that's part of the culture of the place. People recognize that time slots are not a good way to provide health care more generally. But (also) a mindset that's open to working through the problems that need to be worked through in the best way for all parties present. That again, produces a very, very different sense. And it's really valuable to have.

Paul Batalden 18:57
One of the things that I think sometimes happens in places like setting one is that there are tasks, forms to fill out, complexity to be managed and sort of coping with that complexity becomes a competing focus with the actual work that you're doing seeing the patient. And so I'm curious as you reflect on these various settings, how did the sense of complexity or a complex work setting play itself out?

John Brennan 19:34
I suppose again, setting one you're thinking about work in units of time, all of the time. And that's very, you know, I think from the patient perspective, very frustrating too, because you're asking for some help with regard to something the doctor needs to sign or a letter they need to write and the automatic response is?, "Here's the time slot where that will be done," whether that's what you need, or when you need it, or you know, or not.

Setting two though is about, you know, units of care more so and what needs to be done to help with care. So if you take the second story that I gave you. If that gentleman is in with me and part of his worry is that he can't pay his heating bills for the winter. And he has a form from the Council for me to sign that says he's got a medical condition, that he requires support and paying his heating bills from the local authority, that will be signed there. And then because this is part of the worry, this is part of the sleep issue. And it's inbuilt. You know, as a unit of care, it's all that it takes to be put together to work through these complicated problems. The reductionist approach that it's one problem in 10 minutesor whatever else, does not fit. How tricky and difficult optimizing health is in the real world with everything that needs to be (in)?corporated there.

Paul Batalden 20:59

I have a sense that in both setting one and setting two, there are tasks to be done. But the focus is not on the task, the focus is on the person in setting two and the tasks are done as a part of that interaction. But in setting one, the preoccupation with getting the tasks accomplished within the designated time slot becomes a good part of the focus and that's not fundamentally very satisfying as a professional person.

John Brennan 21:29
Absolutely not. I mean, we get our energy and our fulfillment, or certainly I do, from connecting with people, and really finding ways to work with people to solve really difficult problems. I mean, that's the most enjoyable part of the job. When you succeed together with the person who's got that health difficulty, it's not the task completion piece. It's not a checklist, you know, that you're working down through, it's what you achieve together.

Paul Batalden 21:59
Wow, this has been a wonderful conversation. John, I deeply appreciate it. As you were thinking about our time together, you reflected on the various work settings you've been in. Were there other things that you wanted to focus on or bring up, before we bring this conversation to a close?

John Brennan 22:18
I suppose Paul, one of the biggest challenges we see in primary health care is an ever increasing demand on health services related to, kind of, chronic illness. People are living longer, with more illness, on more medications and, you know, having had more complicated procedures, and with more options out there for treatment than ever before, the complexities (are) only building. So in my experience, the settings that adapt to that, and are able to work with that best, are the settings where there is a strong culture of working together to figure out how things can be best approached and worked through with the focus built always on keeping the person at the heart of that. So that's a flexible, adaptive mindset, that idea that we can always be learning, that builds an incredible resilience and bond, I think, between people who are working to provide care. And I really can't overstate how important and essential that is. I think when you're faced with crises, for example, like COVID-19, and how everything has to change overnight, and in that sense, the teams that have been best able to work through that and whatever the next crisis will be, are the teams that are creating a setting together that enables those mindsets and ways of working together.

Paul Batalden 23:47
Thank you very much, John, it's been wonderful talking with you today. Thank you for sharing your stories with us,

John Brennan 23:54
Paul, My pleasure, thank you for having me.

Paul Batalden 24:00
For the coproduction of healthcare service to be effective and meaningful, the lived reality of people, their interactions with one another, the systems they must navigate, and the multiple forms of knowledge that must come together are key. People, whether in the roles of patients or

professionals,bring their knowledge, skill and habits to the tasks at hand. The physical, social and emotional spaces, where they encounter one another, make it easier or harder for everyone in these spaces to do their best. In the relatively straightforward task of medication prescribing, John Brennan helps us see how environmental influences become manifest in the daily work of creating a good healthcare service. Setting one was focused on tasks to be done and working in units of time; setting two was focused on the person and what care was needed. As John noted, in setting two, there was a real team of clinical and administrative folks who worked together. He also reflected that with more chronic illness, there was more complexity that had to be addressed. And he noted that the flexible adaptive way of working made his ability to be a better doctor possible.

If we think of setting one as a task oriented healthcare system, which treats a clinic visit as a product, the visit lasts for X number of minutes, a functioning team sees Y number of visits every hour, each day the team is working, they're available Z hours, the total work involved with visits is X times Y times Z. The scheduling system needed then is one that keeps track of X, Y and Z, and the expected work is tied up with these variables. If, however, the real work needs to address the complexity of real life, as John Brennan described, a setting one system and the assumptions underlying it are at odds with what's needed. Tensions inevitably arise, and professional persons are supposed to somehow manage and reduce the gap between expected and real work of good health care service. This takes time, attention and energy away from the adaptive care and the flexible healthcare service that may be best.

John Ballatt and his colleagues in the UK have described the importance of relationships among staff people who work together, as well as working with persons we sometimes know as patients. They are all people navigating tasks and existing systems to get the work done. John and colleagues describe this network as one that is anchored in “kinshipness,” or intelligent kindness. They note that a system that inhibits kinshipness, risks creating something machine-like instead, like setting one. The professional person in that setting expects standardized contributions, and is effectively discouraged from customizing care and services. John and his colleagues encourage settings that are built on an appreciation of both relationship and task, like setting two. Others suggest that the mechanized way of thinking about the service work involved in health care is a major contributor to the widespread professional person burnout that we see throughout healthcare services today. Adjusting to COVID safety requirements, as added to the diversity of settings in which health care services actually occur in that diversity, the relation of worker to work has taken on greater importance. That's a good thing.

Paul O'Neill, the former CEO of Alcoa, and the legendary leader of a safer, more productive work setting once described the importance of a setting that has the capacity for greatness and a setting in which workers can affirm three things: One, I am treated with dignity and respect every day; Two, I am permitted, trained and encouraged to give my life meaning by making a contribution to the value creating work here; and Three, I am recognized for the contributions I make.

Thank you John Brennan for helping us appreciate the difference that settings have made to your work as a physician person. I'm Paul Batalden.

Madge Kaplan 29:19

Thank you for listening to Episode 10 of the podcast series “The Power of Coproduction” with Paul Batalden. On Episode 11, “From Principles to Practice,” Bill Lucas outlines the learning that's necessary to engage in effective coproduction with patient persons. It doesn't just happen. All podcasts in the series, including an overview of coproduction, are available at ICoHN.org/podcasts. The website is where you'll find supplementary materials, guest bios and brief profiles of the production team. You can subscribe to the podcast series wherever you get your podcasts. Thanks for listening.