General practitioner attitudes to case conferences: how can we increase participation and effectiveness?

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ABSTRACT

Objectives: To identify general practitioners' views on the barriers to using case conferencing (as outlined in the Medical Benefits Schedule (MBS) Enhanced Primary Care package) and to develop a set of principles to encourage greater GP participation in case conferences.

Design: Qualitative study, involving semistructured questions administered to focus groups of GPs, conducted between April and July 2001 as part of a broader study of case coordination in palliative care.

Participants: 29 GPs from urban, regional, and rural areas of Queensland.

Principal findings: Many of the GPs' work practices militated against participation in traditionally structured case conferences. GPs thought the range of MBS item numbers should be expanded to cover alternative methods of liaison (eg, phone consultations with other service providers). The onerous bureaucratic processes required to claim reimbursement were an additional disincentive.

Conclusions: GPs would probably be more likely to participate in case conferences if they were initiated by specialist services and arranged more flexibly to suit GP work schedules.

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PATIENTS WITH CHRONIC or complicated conditions are often managed by a number of clinicians acting independently of one another. Indeed, healthcare systems often promote compartmentalised care, resulting in duplication of services and inefficient delivery of care.[1]

General practitioners provide primary care, with, ideally, an emphasis on the person rather than the disease.[2] They are therefore well placed to coordinate and prioritise the care provided by specialists and other health professionals to patients with complex needs.[3,4] Formal collaborations between specialists and primary care physicians produce limited short-term improvements in health outcomes. However, patients benefit through improved program retention rates and patient satisfaction and improved clinical practice of both specialists and GPs.[1,5] Multidisciplinary case conferences have been trialled in Australia in the fields of diabetes,[6] aged care[7] and attention-deficit/hyperactivity disorder,[8] and show some promise.

In 1999, the Federal Government introduced the Medical Benefits Schedule (MBS) Enhanced Primary Care (EPC) package. This recognised the central role of GPs by introducing remuneration for their participation in the multidisciplinary care of patients with chronic or complex conditions.[9] This included funding for GP involvement in case conferences and development of multidisciplinary care plans.

However, the uptake of case conferencing by GPs has been poor:[10] only 11 095 case conference item numbers were claimed in 2001, compared with 155 486 multidisciplinary care plans over the same period.[11]

The aim of our study was to identify barriers to the uptake of case conferencing by GPs and to determine what factors would encourage GPs to make more use of it as a management tool.

METHODS

Our study was conducted as part of the planning for a randomised controlled trial of case coordination in palliative care.

Thirty-three GPs from urban (Brisbane), regional (Townsville) and rural (north Queensland) areas were invited to participate in focus groups to discuss their opinions of the funding arrangements for multidisciplinary case conferences introduced in 1999.

Half the participants were selected using computer-generated random number tables applied to Division of General Practice membership lists. The remaining participants were GPs who were known to play an active part in divisional activities or administration, or who had a special interest in palliative care. In choosing this mix, we hoped to capture both "grassroots" opinion and the views of opinion leaders.[12]

Between April and July 2001, four focus groups of between five and 10 participants were conducted (two in Brisbane, two in Townsville). Some GPs who lived in distant rural areas or could not travel because of family responsibilities participated by teleconference. The GPs were paid for their participation.

At each location, a group facilitator and a note-taker conducted a semistruc-

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1: Barriers to and benefits of GP participation in case conferencing

Barriers

Compliance issues

- Complex bureaucratic requirements of EPC items.
- Fear of accusation of defrauding Medicare.
- Reluctance to bill patients for items of service not involving contact.

GP work practice issues

- Unpredictable workload.
- Perception that face-to-face consultations have higher priority than case conferences.
- Participation uneconomic, especially when travel to meetings involved.

Cultural barriers

- GPs' perception that their potential contribution not valued.
- Differing work practices (eg, relating to preferred times for meetings).
- Success or otherwise dependent on personality of specialist.

Benefits

- Improved coordination of patient care.
- Provision of potentially efficient means of briefing all professionals.

EPC = Enhanced Primary Care.

tured interview. The sessions were tape recorded, transcribed and analysed using the method of Zemke and Kramlinger.[13] The transcribed tapes and note-taker's observations were used to identify keywords and phrases, which were then categorised and placed into subtopics.[13]

RESULTS

Of the 33 GPs invited to take part in the study, 29 participated: 13 from Brisbane, 10 from Townsville and six from rural northern Queensland. Twelve participated via teleconference. Fourteen had an expressed interest in palliative care.

Perceived barriers to and benefits of case conferencing (Box 1)

GPs described their primary role as providing face-to-face consultations with patients, and had difficulty incorporating other means of practice within that framework. They found it hard to justify the effort involved in organising and participating in case conferences compared with the informal telephone liaison already done regularly. There was some confusion about the rules governing MBS item numbers — participants did not recognise that remuneration could be gained for collaboration via teleconference or videoconference (ie, that physical attendance was not required). There was also concern that patients might be reluctant to be billed for a service for which they were not present.

It was difficult to arrange appropriate times and locations for case conferences. The practical issues of a heavy workload, the unpredictability of general practice, and travel from the surgery to another venue made participation in case conferences, where physical attendance was required, very difficult. Bureaucratic requirements for case conferences were also hard to comply with. GPs' experience in communicating with hospitals, in particular, was mixed, and they questioned whether some hospital services valued a partnership with GPs.

However, some experiences described were positive. Participants could see that regular interaction between GPs and specialist staff could lead to more efficient exchange of information and coordination of care.

Ways of improving the participation rate of GPs in case conferencing

The participants in our study suggested a variety of ways to increase the uptake of case conferencing by GPs (Box 2). They thought the bureaucratic requirements for raising a fee for participation in the more complex EPC items could be simplified (several of the items are similar), and GPs were concerned that they might commit inadvertent errors in claiming EPC items. Additional items for alternative methods of liaison needed to be considered (eg, for telephone consultations with individual service providers, which are the most common means of interprofessional communication). Participants also felt that time-consuming tasks such as palliative care home visits (involving a considerable amount of interprofessional liaison) should attract specific item numbers. Furthermore, they wanted GPs to be consulted about any proposed changes to the scheme.

As for the organisation of case conferences, GPs felt they could be made more efficient by preparing an agenda and having clear expectations of outcomes.

2: Suggestions for improving the uptake of case conferencing by GPs

MBS issues

- Simplify MBS procedures and item numbers.
- Introduce items for phone consultations with other health professionals.
- Introduce items for specific complex situations (eg, palliative care).
- Consult GPs before making revisions to the program.

Case conferencing requirements

- Organise conferences in a way that is efficient but flexible.
- Have clear objectives and procedures.
- Make the process flexible enough to take account of GP operational difficulties.
- Seek GP input in organising conferences.

MBS = Medical Benefits Schedule.

DISCUSSION

Our results confirm previous findings about the attitudes of Sydney GPs to the uptake of case conferencing.[11,14] However, our study was based on the field of palliative care. It is possible that participants brought prior experiences in dealing with palliative care patients and the specialist services that serve them. The findings may differ if other patient groups were being discussed. Most GPs do not plan to use EPC item numbers in a systematic way, and will require support to utilise them.

Although the benefits of good GP–specialist collaboration seem obvious, several factors militate against ready adoption of a case-conferencing approach to patient management. The GPs we interviewed were not clear about the MBS rules governing case-conference item numbers. The work demands on GPs leave very little time to organise or take part in case conferences, and the bureaucratic require-

3: A model for improving the case-conferencing process

- Run case conferences within an established framework of a specialist service (eg, team meetings, regular case discussions).
- Place the onus for organising conferences and obtaining patient consent on the specialist service.
- Give the GP plenty of notice of a meeting (at least two days if possible).
- Use teleconferencing, with the GP phoning in from the surgery.
- Make a formal appointment in a time slot reserved for patient consultation.
- Arrange for the GP to ring in to the conference when the appointment time arises *or* to ring within a specified time period.
- Make sure that the specialist service takes case notes and forwards a copy to the GP.

ments are another disincentive to GP participation in the program.

Encouraging specialist services to initiate case conferences with GPs may be a more effective way to get GPs involved. Specialist teams and larger organisations, which already have an established framework for team interactions, may find the requirements of case conferencing easier to adhere to. The specialist service would have to bear the administrative load, but the return, in terms of enhanced GP knowledge and patient quality of life, could be well worth the investment.

From our consultation process we developed a model incorporating participants' suggestions for improving the case-conferencing process (Box 3). The model is incorporated into the routine of the specialist services involved and takes into account the work practices of GPs. Using the model, we subsequently successfully conducted over 20 case conferences between GPs and three different palliative care services in Queensland, with GPs as willing participants. It relates specifically to services that already incorporate regular team meetings or case meetings. Some disciplines work like this as a matter of course — in particular, psychiatry and some complex medical and paediatric disciplines. In disciplines that do not use this approach, other means of engaging GPs might be necessary.

COMPETING INTERESTS

None identified.

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