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ORIGINAL RESEARCH

The Intervisions Cliniques Continuing Medical Education Program: A Forum for Exchange and Mutual Knowledge Development between General Practitioners and Psychiatrists

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Abstract

Objective: This article presents the Intervisions cliniques program, a Continuing Medical Education (CME) initiative for psychiatrists and general practitioners which uses case discussion to foster the acquisition of mental health care knowledge.

Method: This project is a case study, using qualitative methods. An operational model of Intervisions Cliniques was drawn for analysis. Data mainly come from the program-related literature, direct observation and interviews with 9 key actors, assembled in 2 groups of promoters and participants of the program.

Findings: The findings help to define the context and vision in which the Intervisions cliniques program was set up and implemented, to identify the perceived benefits and disappointments with regard to the program. Set up in the Canadian public managed care system and university-affiliated hospital, the Intervisions cliniques program helps to create lines of communication and privileged exchanges between general practitioners and psychiatrists as well as to foster mutual knowledge and a crosscutting and interactive view within a shared clinical territory. Several benefits noted by the participants and the organizing committee demonstrate the importance and multimodal effects of this type of initiative. The case-discussion format used as a CME method meets the training needs of general practitioners and is widely appreciated. However, the pressing needs expressed by the general practitioners with regard to improving shared mental health care still pose many challenges.

Conclusions: Making the link with the duties of responding psychiatrists, who are now funded in Québec, seems to be part of the solution. Maintaining and disseminating the Intervisions Cliniques program will require provincial-wide system implementation strategies to train psychiatrist, support them and regional managers to monitor the quality of this innovative practice within a public managed care system.

Clinical implications

- In the context of Continuing Medical Education (CME), case discussions are valued because they help to address the full complexity of clinical situations.
- In the development of shared mental health care, direct contacts between general practitioners and psychiatrists are an optimal way to foster mutual knowledge and a cross-cutting and interactive view within a shared clinical territory.
- The Intervisions cliniques program contributes to shared mental health care and is a CME strategy that should be reproduced.

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Limitations

• The operational model presented cannot identify all the links which unite the structures, processes and effects of the Intervisions cliniques program.

•Interviews with local and regional managers would have helped to better determine all the issues involved in maintaining and generalizing the Intervisions cliniques program.

•Clinical examples illustrating experiences of shared mental health care following participation in the Intervisions cliniques program would have helped to better determine what contribution the Intervisions cliniques program has made to shared mental health care.

Keywords

Shared care, Primary care, Mental health, Responding psychiatrist, Continuing medical education, Case discussion, Health services research

Introduction

In Quebec as well as in the rest of Canada, general practitioners play a crucial role in the delivery of mental health care as part of the follow up of common and serious mental disorders. The Canadian Community Health Survey has shown that general practitioners are the most often consulted health professionals by individuals affected by a mental health problem [1,2]. More than 15% of the adult population in Quebec (total population of 8 millions inhabitants) or other Canadian provinces have sought help from general practitioners for mental health reasons [3,4]. Of this number, 50% of clients were followed up only by the general practitioner, while the other 50% were also followed up by another health professional [5].

To ensure access, quality and continuity of mental health services through primary health care as represented by family physicians, various measures have been put forward in Quebec and Canada. A working group including the Canadian Psychiatric Association and the College of Family Physicians of Canada has examined shared mental health care. Among the aspects examined, the importance of collaboration between general practitioners and psychiatrists was noted [6]. An exploratory study conducted in Quebec among a representative sample of general practitioners and psychiatrists in Montreal identified three strategies to promote collaboration between the two groups of physicians [7]: 1- Improving communication, 2- Broadening access to responding psychiatrists and, 3- Providing Continuing Medical Education (CME) in psychiatry to general practitioners. This last strategy received enthusiastic support by general practitioners and psychiatrists [8].

Different formats can be adopted for CME. Some are more traditional, such as lectures given by a specialist to a large audience, and others less traditional, such as training workshops or discussions focusing on clinical cases. The literature on methods of transferring medical knowledge between general practitioners and specialists has identified "problem-based learning" as the most effective strategy leading to a change in practice [9]. "Problem-based learning" begins by exposure to a clinical problem with learning taking place through a process of understanding and solving this problem [10,11]. Although the effect observed in terms of knowledge acquisition and changes in practice is only moderately greater for "problem-based learning" compared to traditional methods, this method has been most favoured by the majority of physicians and gives rise to greater motivation and satisfaction [12-17]. A review of the literature on the organization of CME activities based on case discussions and "problem-based learning" has helped to identify the few publications on the subject and the need to further document best practices in CME and the organizational issues involved in implementing this type of activity for general practitioners and psychiatrists [18]. The opportunity came up in Montreal with a CME initiative involving psychiatrists and general practitioners using case discussion to foster acquisition of mental health knowledge: the *Intervisions cliniques* program.

More specifically, this article aims to:

- Describe the *Intervisions cliniques* program as implemented in a university psychiatric hospital with a catchment-area responsibility for the east-end of Montreal (circa 500,000 inhabitants);
- Identify the medical education vision and needs met by this approach; and
- Explore the challenges involved in implementing the *Intervisions cliniques* program and the conditions that would be conducive to maintaining and generalizing the program.

Methods Used

Case study is defined as an empirical investigation which examines a complex phenomenon in its context by resorting to multiple sources of explanation [19]. The methods used pertain to the field of evaluative research, i.e. which uses a scientific methodology to analyze the links existing between the structures, processes and expected effects of an intervention, in this particular case, the *Intervisions cliniques* program [20]. The data come mainly from the program-related literature, direct observation and interviews with key actors.

Nine key actors were interviewed: 1- Members of the organizing committee (these promoters were general practitioners and psychiatrists) and 2- Participating general practitioners. The participating members were selected through rational sampling to ensure a variability of responses. Regular and occasional participants working in different medical practice contexts were chosen. In total, four participating general practitioners were interviewed individually and five organizing committee members were interviewed as a group. The interviews lasted approximately 90 minutes. They

explored various major themes such as the context of the program's emergence and implementation, the perceived effects and benefits, upcoming challenges and the conditions that would be conducive to maintaining and generalizing the program.

The interviews were taped and transcribed for analysis. The strategy used involved analyzing the content of the key actors' comments. More specifically, a mixed content analysis method was used, i.e. based on predetermined categories and some emerging categories [21]. NVivo software was used to support the content analysis. The analysis was conducted by a research assistant closely supervised by first author CB. An operational model was also constructed by CB to explain the theory behind the intervention, identifying links between the program's structures, processes and expected effects.

The project was approved by the scientific and ethics committee of the Research Centre of the Institut universitaire en santé mentale de Montréal and was evaluated by an independent researcher who was not a member of the organizing committee of the *Intervisions cliniques* program (i.e. the first author of this article).

Study Findings

Context in which the Intervisions cliniques program was set up and implemented

Canada's universal healthcare system covers 99% of the population. It is administered by the provinces, and physicians are mostly self-employed and paid on a fee-for-service basis [22]. The activity was initiated by psychiatrists in Quebec to foster better collaboration between general practitioners and psychiatrists in an urban area now of 500,000 inhabitants served by a university psychiatric hospital (in eastern Montreal). The activity consisted of bimonthly meetings lasting 2 to 3 hours and focusing on cases brought forward by the participating general practitioners. The themes addressed were not predetermined: they related, variously, to diagnosis, the therapeutic relationship, medication and/or psychotherapeutic treatment options, the organization of services, etc. Publicity and communications about the activity were carried out by a pharmaceutical company which also covered the expense of the meal provided at the meeting. However, no publicity for this company's products was made during the activity. CME credits, recognized by the Federation of General Practitioners of Quebec, were awarded to the general practitioners for their participation. The participating psychiatrists were mostly members of the organizing committee and were associated with an adult clients program at the university psychiatric hospital. They participated in the activity on a voluntary basis, although some initially received compensation from the pharmaceutical company.

The *Intervisions cliniques* program was implemented at the beginning of 2008. The 6 meetings per year organized in 2008-2009 and in 2009-2010 (n = 12 meetings) involved 28 individuals: 19 general practitioners, 3 gerontopsychiatrists and 6 organizing committee members (including 3 psychiatrists, 2 general practitioners and 1 psychiatric resident). At each of these meetings, the number of participants ranged from 7 to 14 and, on average, two cases were discussed.

Vision and Benefits of the Implemented Program

The promoters' vision

As illustrated by the operational model (Figure 1), the *Intervisions cliniques* program proposes a privileged line of communication and exchange whereby general practitioners and psychiatrists can create links and learn from each other. This is the main goal of the organizing committee made up of psychiatrists and general practitioners.

According to the organizing committee, this privileged forum for exchange created as part of the *Intervisions cliniques* program allows general practitioners to have access to the opinion of psychiatrists, validate their own interventions and gain assurance with regard to their mental health interventions. For the psychiatrists, this forum fosters a better knowledge of the needs of primary care, an awareness of the reality of general practitioners and a reduction in mutual prejudice.

The *Intervisions cliniques* program fosters a cross-cutting and interactive view between psychiatrists and general practitioners such that their respective visions come closer together.

The General Practitioners Participants

The general practitioners interviewed for the study largely described this situation as "two solitudes". General practitioners have little or no access to psychiatrists and links with the latter are made through formal written notes without any direct communication. There is a real dissatisfaction with the current situation in mental health where the establishment of shared care is slow.

The *Intervisions cliniques* program thus came about within a context of dire need for collaboration and training, and of dissatisfaction with the current situation. Indeed, the *Intervisions cliniques* program appeared to provide some tentative solutions. First, the format of case discussions was highly appreciated since it met the needs linked to the daily practice of general practitioners by offering them the opportunity to discuss cases in all their complexity, taking account of all the issues and obstacles.

The collegial structure in which everybody participates voluntarily and freely was also a highly valued format which appeared to foster learning.

Moreover, the *Intervisions cliniques* program enables

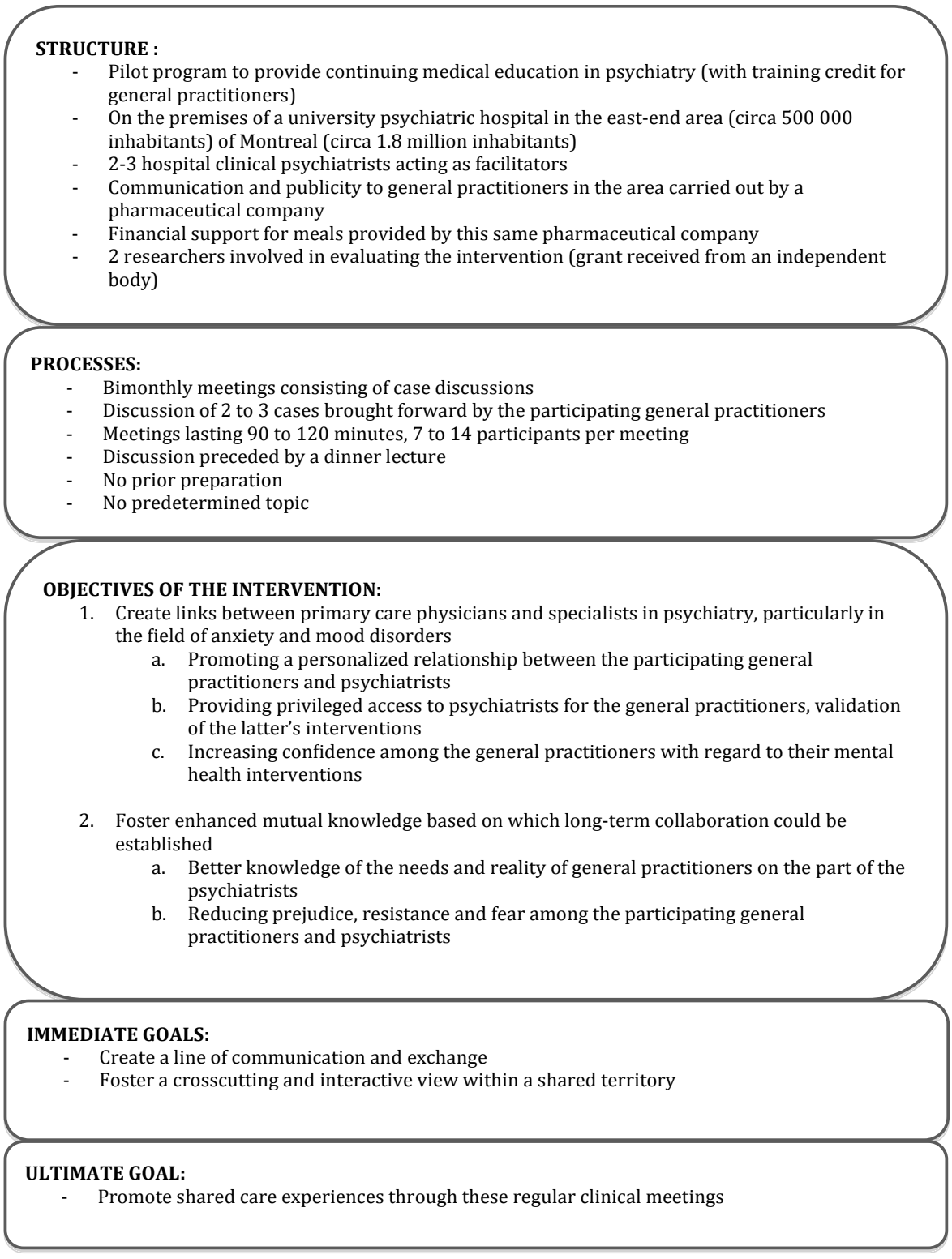

Figure 1: Operational model of the Intervisions cliniques program.

the participating general practitioners to improve their knowledge in psychiatry and to compensate for the lack of direct contact with psychiatrists and their colleagues.

The *Intervisions cliniques* program enables general practitioners and psychiatrists to get to know one another better and to gain a better understanding of the two realities represented by the work of general practitioners in primary care and psychiatrists in specialized settings.

Challenges Facing the Intervisions Cliniques Program and its Maintenance

Unmet needs

Despite the benefits, the *Intervisions cliniques* program has also given rise to disappointments. Although links have gradually been created between physicians in the same sector through the *Intervisions cliniques* program, the latter cannot meet all the challenges posed by needs related to shared mental health care. The *Inter-*

visions cliniques program is a CME activity outside the formal structures of collaboration. It does not replace the responding psychiatrist[a]. Moreover, the general practitioners interviewed deplored the lack of communication among themselves and with psychiatrists outside the sessions and the very little information transmitted regarding the physical and organizational structures of the sector's mental health network.

Several comments emerged from the accounts of the participants and organizing committee members with regard to the role played by the *Intervisions cliniques* program in improving institutional links in the territory served and establishing real shared mental health care. For some participants, the program did not meet this goal. For others, this was not the program's goal.

Maintenance of the Program

For many participants, it was quite clear that the *Intervisions cliniques* program is a CME initiative offered on a voluntary basis rather than a formal activity aimed at improving institutional links. Moreover, the idea of formalizing it within the structure of services in order to increase the impact on shared mental health care in the territory has not necessarily won unanimous support. It would be useful to formalize the *Intervisions cliniques* program to a greater extent so as to foster its growth and sustainability. However, there also appears to be a desire to keep the initiative outside institutional links, in a climate of collegial neutrality free from organizational issues.

Other comments and suggestions have emerged with regard to the need for the *Intervisions cliniques* program to broaden its field of expertise and thus, to better meet the interests and needs of all the participants. For example, the different types of practices of general practitioners certainly require the expertise of psychiatry but also the expertise of other related disciplines such as geriatric psychiatry. Thus, the participants expressed the view that the structure should be more flexible and several suggestions were put forward. Should several subgroups be developed, with each addressing different themes and areas of expertise, adapted to the level of experience and knowledge of the participating general practitioners and their type of practice? Should the meetings be moved to the practice locations of the general practitioners? Should the meetings be held at lunchtime rather than in the evening and should they be more frequent? This demand for a rapid adjustment to the general practitioners' needs would certainly require increased coordination and a closer link with the general practitioners in the territory. Moreover, although the involvement of the pharmaceutical company facilitated the implementation of the *Intervisions cliniques* program, additional resources emerging from the public sector should nevertheless be provided in order to broaden and maintain the project.

Discussion

Sieu, et al. [18] described from the literature the essential parameters to be maintained in order to foster learning through case discussion in the CME context: predetermined monthly or bimonthly meetings to be held at the workplaces of general practitioners, lasting 60 to 120 minutes, with 4 to 10 participants including general practitioners and medical specialists, and a facilitator (generally a specialist) who leads the discussions, etc. *Intervisions cliniques* met these parameters. The participating general practitioners appreciated the case discussion format, where cases were chosen by them to reflect their clinical reality. The participating general practitioners also appreciated the climate of exchange and collegiality made possible by the small number of participants at each meeting (7-14 participants), at a place of their choice and by the voluntary nature of participation.

There are limitations and strengths to this study. The small number of respondents echoed the size of the initiative that did not involve more than 30 participants. However, it would have enriched the data to interview some regional and provincial policy-makers about the maintenance and dissemination of the program: we can only speculate about these issues. Clinicians, either psychiatrists or General Practitioners, would have appreciated examples of the clinical vignettes that were discussed, but space did not allow to detail further. The strengths were the independence of the health services researcher (CB) who developed the operational model from the literature and emerging material from the interviews that allow to go beyond the themes not covered to now speculate about how to set up, to disseminate and to monitor quality of this program.

The *Intervisions cliniques* program are indeed at a turning point, since it was not pursued in this particular setting beyond 2013. Moreover, the pressing needs expressed by the general practitioners with regard to improving shared mental health care and the coordination between primary and secondary care across the entire territory pose greater challenges to specialized psychiatry which cannot be met by the *Intervisions cliniques* program alone. How can the program remain an innovative continuing education initiative and also have increased impact on shared mental health care in the territory served?

Recognizing and funding responding psychiatrists in Quebec (1 equivalent full-time psychiatrist provided for

[a] The term responding physician has increasingly been replaced by the term medical specialist responding in psychiatry. The medical specialist responding in psychiatry has the duty to support primary mental health care in order to meet the needs of the population in a given territory and to ensure the bidirectional liaison between primary mental health care and secondary psychiatric care in this territory. It is reimbursed as sessional fees to psychiatrists by the public physician billing agency since 2010 (RAMQ, info-138, september 2010).

every 50,000 inhabitants, in a province counting about 1 psychiatrist per 8000 inhabitants), whose description can be found in the footnote earlier [23], is a solution adopted in the province of Quebec to maintain and integrate essential strategies for shared mental health care and continuing medical education programs such as *Intervisions cliniques*. As suggested by psychiatrists and general practitioners [7], the additional fruitful shared mental health care activities carried out by the responding psychiatrist can be manifold: providing on-site support to the general practitioners' offices in the territory; answering telephone consultations from general practitioners; discussing cases; exceptionally participating in the evaluation of certain patients; and probably, contributing to enhancing the clinical mental health skills of primary health care professionals working in the general practitioners' offices.

Implementing such innovative program at the system level in a public managed care system in place in Canada, requires four elements: governance, funding, training and evaluation [24]. Already, the provincial ministry of health and its mental health directorate have created and funded the responding psychiatrists' scheme. However, the ministry has not supported training psychiatrists in the new role, nor monitored the implementation of the responding psychiatrists program. A review of the system implementation strategies showed that state technical assistance centres shall be considered [25]. Such centres provide initial training of the innovative program, community of practice monthly discussion, monitoring of quality and accreditation. Quebec's mental health directorate has already set up such a technical assistance center for the implementation of the program for Assertive Community Treatment for severely mentally ill patients [26]. It would require further governance to dedicate new staff to this additional activity of its technical assistance center.

Conclusion

It remains an hypothesis that shared mental health care will lead to better care and outcomes of patients with common mental disorders. Among these disorders, predominate depression that is often co-morbid with other common chronic disorders seen in primary care like hypertension, diabetes, cardio-vascular diseases [27]. For these common disorders, the chronic disease management model in primary care involves a role for other medical specialists to support general practitioners in a comparable manner as we suggested for responding psychiatrists [28,29]. Further studies shall therefore examine not only the impact on psychiatric and physical diseases outcomes of the responding psychiatrists, but also the development and implementation of other responding medical specialists in the primary care context.

From this perspective, it is hoped that the chosen approach regarding responding psychiatrists, supported by a ministry of health's technical assistance center, will lead these mental health medical specialists to devote part of their time to the *Intervisions cliniques* program and that their activities will enhance the potential for better collaborative care and better mental health care for the population.

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