**A Summary of the Development, Evolution and Current Status of**

**“Practice Inquiry (PI) Colleague Groups”**

***(DRAFT November 2020)***

**First Phase Development**

“Practice Inquiry (PI) Colleague Groups” are regularly scheduled, facilitated, practice-based venues for primary care clinicians to address their current challenging patients. These include diagnostic or management dilemmas, ethical and prognostic conundrums, patient-clinician relationship concerns, or combinations of all of these. 1, 2

In 2002, PI Colleague Groups were first piloted with a narrow research focus:

* To develop an epidemiology of clinical uncertainty for primary care practice using concurrently collected, individual case data based on clinician presentations of patients at small group meetings in selected primary care practices in Northern California, and
* Through an analysis of these data, to identify PCP educational and skill needs

From 2002 through 2015, a 460-case series had been accrued; interim findings have been presented at two national meetings in the last 3 years. (See attached poster.)

By 2005 when PI Colleague Groups became an accredited CME program at University of California San Francisco, first in the Department of Family and Community Medicine and then in 2011 in the Department of Hospitalist Medicine (“Cases and Conundrums’), it began clear that the regularly scheduled, PI Colleague Groups were meeting different needs than those originally expected. The regularly scheduled groups:

* Afforded opportunities for providing focused, clinical support to clinicians in managing challenging, individual patients on all levels – biomedical, psychosocial, interpersonal and ethical uncertainties often intertwined, along with the more classic diagnostic, management, and prognostic ones, singularly or in combination
* Lined up with ‘intrinsic motivators” that research has shown contributes most to physicians’ professional satisfaction and well-being: Working in a learning culture with colleagues that supports giving excellent care to each individual patient through enabling clinicians to exercise clinical judgment. This is in contrast to ‘extrinsic motivators,’ both of the individual (e.g., gym memberships, support groups2 ,3)) or of the organizational kind (e.g., team-based care, technology fixes4) where interventions are based on both maximizing clinician efficiency and resiliency while sidelining what matters most to clinicians – the care of the individual patient. 5,6
* Created the scaffolding of a learning community for clinicians whose mental health and welling as professionals have depended upon having the resources to meet individual patients’ needs.

**Second Phase Development**

By mid-2015, PI Colleague Groups continued to meet, clinician attendance increased, institutions provided CME credits, free lunches and occasionally, set-aside time to come together. Between 2014 -2018, Sommers had been hired to train clinicians to facilitate their own PI Colleague Groups in 2 regional health systems (Northern California Kaiser, Sutter Northern California); a national, membership-based, primary care organization with 100 offices (One Medical); and a non-for-profit San Francisco Bay Area primary care organization with 10 neighborhood health centers (Lifelong).

At any one time, ~25 Colleague Groups were meeting around the country on a regular basis in these systems as well as in sites where Sommers had introduced PI starting in 2002: county health department clinics or federally-funded neighborhood health centers, University Faculty Practices (University of California, San Francisco, Department of Family and Community Medicine; Stanford, Department of Family Medicine), and in three, Family Medicine residency programs with separate PI groups for residents and for faculty (Dartmouth, University of Virginia, and Tufts. The clinicians that Sommers trained as PI Colleague Group facilitators in these sites starting in 2008 became ‘colleagues’ who subsequently contributed to the evolution of the methods and its dissemination to other parts of the US as they moved to new positions, introduced PI to their new organizations, and trained new facilitators.

By early 2017, Sommers and colleagues began noticing that although PI Colleague Group setting were affording PCPs with opportunities they rarely have had before - to air current, perplexing cases to elicit help from practice colleagues, they suspected that the vast majority of everyday, bread-and-butter clinical uncertainty doesn’t reach the once or twice-monthly Practice Inquiry Colleague Group. The work done in the groups relies totally on clinicians’ recollections of patients they encountered in recent clinic visits; rarely would a clinician present a patient seen longer than a week before the meeting. Therefore, Sommers and colleagues lacked insight regarding:

* How frequently clinicians’ experience ‘not knowing’ in the patient visit yet soldier on, making decisions with varying levels of certainty, comfort with uncertainty, and satisfaction with visit outcomes
* The nature of patient presentations that occasion clinical uncertainties
* How clinicians respond to uncertainties, how patients react to these responses, and how visits conclude given the uncertainties

All the above could be valuable for informing PI methods so that the nature of the decision-making challenges PCPs face daily in the visit could be addressed more specifically in the PI group. This would allow for a more explicit and effective transfer of skills from what’s learned in the group to the clinical encounter. Furthermore, documentation of the scope and depth of the uncertainty work PCPs do could help advance insight into their critical role at the portals of the health care system, advocate for increasing their support on every level, and more explicitly recognize their special expertise in managing clinical uncertainty.

In addition to positing that the patients that came to PI meetings represented the tip of the iceberg, Sommers and colleagues wondered to what extent PCPs had normalized clinical uncertainty as their daily fare, playing down its frequency and disruptive nature, even becoming immune to it, possibly to their peril. The carton that David Foster Wallace made famous in his 2005 Kenyon College commencement address aptly describes the extent of PCPs’ immersion in their ‘water’:

Graphical user interface, diagram, application

Description automatically generated

In late 2019 – early 2020, Sommers and colleagues initiated “The Water Project” to explore these questions. To learn more about the frequency of and nature of significant within-visit uncertainty, eight San Francisco Bay Area PI Colleague Groups tried out an exercise in which they recalled and reflected upon the patients they saw in their most recent clinic before the meeting. The focus was on patients that, for whatever reason, the clinicians experienced one or more instances of ‘not knowing’ within the visit, how they dealt with it, and whether or not the uncertainty was resolved. These groups met in between January and early March of 2020.

The attached poster summarizes the project. (The poster was presented at the 2019 year’s Diagnostic Error in Medicine conference in Washington DC.) The following was learned from this brief exploration:

* On average, of the 7-10 patients the PCPs saw in a half-day clinic, 3-4 patients presented some type of significant uncertainty during the course of the visit
* Of these 3-4 patients, 1-2 remain troubling after the visit concluded
* In the meetings, the clinicians exchanged this information and chose one or two of patients with unresolved uncertainties to discuss during the time remaining in the meeting

Overall, the groups were surprised to find that for 13%-20% of the patients reviewed in the exercise, significant uncertainties remained after the visit. The question requires further investigation: Do 13%-20% of patients seen daily comprise a daily ‘uncertainty’ burden to PCPs? If so, how do they manage it? What is its impact on the quality of care they provide and on their personal well-being?

**Third Phase Development**

As of early Spring 2020, most PI groups that had been meeting on some regular basis had stopped meeting face-to-face. Starting in mid-summer 2020, some groups resumed meeting via Zoom. To-date, L. Sommers has attended six Zoom PI Colleague Groups with six more planned through the end of 2020.

After the first two Zoom meetings, it became apparent that the nature, frequency, and intensity of clinical uncertainty in the COVID-19 era had changed dramatically. Not only is COVID -19 itself a constant presence in the exam room but the exam room itself has been transformed by telehealth. The telehealth platform had introduced an over-arching context that has to be addressed raising innumerable logistical and clinically important dimensions (e.g., completing a cognitive assessment, decision-making regarding the need for a in-office visit). At these meetings, thumbnail descriptions of cases presented for possible in-depth during the PI Zoom meeting included:

* A 75 yo male with a history of valvular heart disease presenting on a Friday with COVID-like symptoms but testing negative for COVID 2 days ago
* 60 yo female with chest pain of 6- hour duration, 2 days ago now resolved; afraid to go to ER or to cardiologist’s office when she was symptomatic
* 45 yo female post-COVID (she thinks) now worrying about her family and when to go back to work
* 32 yo male unemployed with significant mental health problems and COVID-like symptoms
* 53 yo female post- COVID, now testing negative but with new onset fatigue and brain fog

The continuation of PI Colleague Groups using Zoom provides the opportunity for capturing clinical uncertainty for primary care clinicians in the COVID-19 era while providing the trusted learning venue that served many so well over the years. This work is now underway as a ‘pilot project’ in the primary care offices of One Medical in 15-20 of their clinics. Two other health systems have been approached regarding participation. (Given the telehealth platform and its unknowns for achieving the basic results clinicians have counted on for PI, the ‘Water Project’ exercise is currently not being offered; it could be added later depending on the individual group’s priorities.)

The purposes of this Pilot Study include:

* Continuing to develop the PI Colleague Group interactive process and orient it to a telehealth platform with the over-arching interest of providing material support to PCPs in clinical decision making for individual patients
* Creating a deliberate practice environment that enables the individual PCP to transfer new decision-making skills learned in the PI Colleague Group to the patient encounter
* To relook at the epidemiology of clinical uncertainty in primary care practice in the COVID era and compare it to pre-COVID period
* To identify knowledge and skill gaps so that participating health care organizations and systems can plan education programs and make system changes based on clinician education/skill needs as determined by their patients (as opposed to what educators or administrators believe they need)
* To accrue a small case series (50-60 cases) for the purposes of:
  + Presenting findings at the upcoming Society of General Internal Medicine National Conference (to be held virtually in April 2021)
  + Deciding whether to partner with a university-based research team with resources to support the effort (creating, analyzing, and publishing, based on a 400-500 case series)

**Pilot Project Logistics Include:**

* PI Colleague Group facilitator notifies L. Sommers (or another colleague) of the date and time of a PI Zoom that she can observe and collect data with group’s permission
* L. Sommers or colleague completes data form for case and discussion (see attached); sends form to PI group facilitator for edits; and provides meeting debriefing to facilitator if requested

Case accrual will continue through March 2021.

**BIBLIOGRPAHY**

1Sommers LS, Morgan L, Johnson L, Yatabe K. Practice inquiry: clinical uncertainty as a focus for small-group learning and practice improvement. J Gen Intern Med. 2007 Feb;22(2):246-52.

2L. Sommers, J. Launer (editors). Clinical Uncertainty in Primary Care: The Challenge of Collaborative Engagement. Springer, New York, July 2013.

3DeChant PF, Acs A, Rhee KB, Boulanger TS, Snowdon JL, Tutty MA, Sinsky CA, Thomas Craig KJ. Effect of Organization-Directed Workplace Interventions on Physician Burnout: A Systematic Review. Mayo Clin Proc Innov Qual Outcomes. 2019 Sep 26;3(4):384-408. doi: 10.1016/j.mayocpiqo.2019.07.006. PMID: 31993558; PMCID: PMC6978590.

4Shapiro J, McDonald TB. Supporting Clinicians during Covid-19 and Beyond - Learning from Past Failures and Envisioning New Strategies. N Engl J Med. 2020 Oct 14. doi: 10.1056/NEJMp2024834. Epub ahead of print. PMID: 33053277.

5Blumenthal D, Kilo CM. A report card on continuous quality improvement. Milbank Q. 1998;76(4):625-48, 511. doi: 10.1111/1468-0009.00108. PMID: 9879305; PMCID: PMC2751093.

6Hartzband P, Groopman J. Physician Burnout, Interrupted. N Engl J Med. 2020 Jun 25;382(26):2485-2487. doi: 10.1056/NEJMp2003149. Epub 2020 May 1. PMID: 32356624.