

Connected at the joints

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THE EMERGING AGENCIES OF PRIMARY CARE PLUS AND BEYOND

Going back to the three promises of Primary Care Plus and the trends in the delivery of health care that they resonate with, the practical implications of the findings of the dissertation become clear. The first promise of Primary Care Plus that I identified is that the vertical collaboration, i.e. the collaboration between general practitioner and medical specialists, will yield a learning process. Primary Care Plus' promise of learning through collaboration, I argued in the second chapter, fits the current trend in health care to use care integration, i.e. the collaboration of professionals from different care sectors as a strategy to "enhance quality of care and quality of life, consumer satisfaction and system efficiency" (Kodner & Spreeuwenberg, 2002, p. 3). To be more specific, the promise of learning through vertical collaboration fits the model in which medical knowledge of different health care professionals is integrated and thus improved through collaboration.

In the third chapter, I showed how Integrated Care does not unproblematically flow from designing a model in which professionals from different disciplines work together. By tracking integrated-care-in-action, thus, the work required to make interdisciplinary collaboration run fluently, I learned that it is not so much full alignment (integration) that is required. Even after the diverse and extensive knowledge work conducted by the professionals participating in making organizational decisions in the Primary Care Plus meetings, there was still a rather high level of fragmentation between knowledge worlds. In literature, interdisciplinary collaboration is often defined as collaboration across disciplinary boundaries (Kodner & Spreeuwenberg, 2002). Yet, the above described findings of the dissertation renders the

metaphor of boundaries and borders in speaking and writing about such collaboration problematic. When managing, conceptualizing, or understanding interdisciplinary collaboration, it might be more productive to think in terms of sequences and joints than of areas that are separated by boundaries that need to be crossed. These findings also endorse Szerszynski and Galaragga's (2013, p. 2817) critique on what they call the "integrative imaginary", by which we "mistakenly assume that disciplines can be combined in a straightforward way to reveal different aspects of the same underlying world". In line with their argumentation, I would argue for a more reflexive imaginary for interdisciplinary collaboration in the delivery of health care, i.e. in conceptualizations of Integrated Care, one that makes space for heterogeneity and multiplicity of knowledge worlds of different disciplines involved in collaborating.

In literature about Integrated Care, a tendency to strive for homogeneity of knowledge can be discerned. With the findings of chapter three, I would argue the opposite. Full integration of knowledge, a homogeneous body of knowledge within an organization, is not needed and might even cause problems in the practice of managing and delivering health care. Full integration comes with reduction of knowledge, inevitable when making different and incompatible knowledges fit one body. Such reduction often comes with a hierarchy. It depicts a medical specialist to have in-depth knowledge about one specific specialty, and general practitioners have broad but superficial knowledge about diverse specialties. When taking these knowledges as compatible, as able to be integrated, a specialist is often considered more knowledgeable about one topic than a patient. Instead of striving for homogeneity, I argue here that it is the heterogeneity that should be protected, counterintuitively, even in practices of *Integrated Care*.

In the instances of knowledge work that I have shown, full integration was hardly ever needed for organizational processes to run fluently. Often, professionals proved to be able to agree on a course of action without resolving differences, i.e. while maintaining the internal diversity. Connecting through joints, as the anatomical metaphor suggests, allows for flexibility. Internal knowledge differences allow for a collective to be more attentive to signals and frictions, for upcoming problems and opportunities. Furthermore, a heterogeneous collective is more productive in coming up with creative solutions for unexpected obstacles on the road. For the interdisciplinary organization of Primary Care Plus to flourish, space for a diversity of knowledge practices and for the work required to create joints between them is crucial, not getting the different professionals to integrate their diverse and often conflicting bodies of knowledge.

In practice, protecting heterogeneity means being mindful when using reductive management devices that discipline doctors, patients, and professionals to act in a

uniform way, such as basing management decisions on outcome measures alone, adopting uniform schedules, or formats for the indication lists. Another point of attention would be to keep the tendency to define problems top-down in check. For example, in the third chapter, I described how in the course of a discussion in the users' council meeting, *the* referral problem became the problem of general practitioners not referring in a way that would be right from the medical specialist's point of view. This tendency became especially noticeable when the scientific research was mentioned that based its analysis merely on the final diagnoses made by the medical specialists during specialist consultations. In contrast, the plan to make teams of medical specialists and general practitioners compose indication lists together can have the opposite beneficial effect on the internal knowledge heterogeneity. If such a team succeeds in incorporating insights from both positions, this will create space for heterogeneity in the organizational processes of Primary Care Plus and in how the actions of involved doctors are evaluated.

This brings us to the learning aspect of the first promise of Primary Care Plus. By reconceptualizing the notion of Integrated Care and particularly the knowledge concept presumed in its promises and expectations, the learning effect seems to have become irrelevant. Knowledge in the analyses of chapter three is not something like a commodity that can be unproblematically transferred from the one to the other, neither something that resides in the mind and can be obtained by exchanging knowledge with people who have other knowledge in their mind (mentalistic view); it is a practice in which sufficiently attuning the differences is crucial for making organizational processes run. However, as became clear in the fourth chapter, even if we take Primary Care Plus as a practice of delivering and managing specialist care, learning processes are and should be central to how the organization is managed and assessed.

In the fourth chapter, I presented how learning processes could help develop Primary Care Plus as a specific form of specialist care. Space for experimentation for providers of Primary Care Plus, I argued, potentially yields fruitful new views, skills and solutions for broader problems in the Dutch health care system. For example, when analyzing the consultation of internal medicine, it became clear that the specialist had developed an intricate routine of dealing with patients with what she referred to as "trust issues". Such patients, in her view, often have a problem finding the care they need and will go from specialist to specialist. This is particularly interesting for the intervention of Primary Care Plus, because it seamlessly fits one of its most important goals to help keep the Dutch health care system accessible in the future. In the assessment methods of Primary Care Plus, the emphasis has been on making the care delivery efficient without being detrimental to the quality

and accessibility of care. A noted but underexplored possible contribution of the intervention is to develop Primary Care Plus as a new and promising form of care in how it is done in the consultation room. The example of the specialist of internal medicine could function as an exemplar and thus a starting point of developing the conditions in which new and unexpected routines will likely come up. Importantly, developing such a routine, I emphasized, had not been an abstract process unfolding in the mind of the specialist (mentalistic view) but a practice of action and reflection. In practice, such processes could be stimulated and noted by organizing, for example, regular training sessions in which specialists view how they themselves and others deliver Primary Care Plus to reflect on and learn from.⁴⁵ However, typically such processes will not have immediate visible positive effects on the cost-efficiency. Allowing space for experimentation and making such experimentation fruitful requires patience and a longer vision for the future.

The second promise of Primary Care Plus is that by relocating specialist consultations from outpatient clinic in the hospital to two neighborhood centers, specialist care would become more accessible. In marketing material, interviews and mission documents, this was emphasized both in a literal (the centers are close to where patients live) and in a transitive sense of the word (friendly, non-hierarchical social interactions between patients and doctors). With the Triple Aim approach, the effects of such accessibility was measured as part of improved patient experience.

Focusing on the patient experiences as one of the three important aims of the care intervention, I argued in the second chapter, fits the current emergence of patient-centered care. The many review and research articles that have been published about patient-centered care can be read as a quest to find the essence of patient-centeredness or the correct yardstick that would enable to compare different practices in the same terms. As such, this quest is phrased in the representational idiom, because it is the activity of finding the right methods and definition to enable creating assessments of practices that reflect or correspond to how patient-centered the intervention actually is. I argued that a representational notion of morality was assumed, because the intervention is seen as a way to make the intervention-reality comply increasingly to predefined standards of patient-centeredness or preset categories that make comparison possible.

On the basis of the ethnographic research, I concluded in the fourth chapter that while most of such conceptions of patient-centeredness understand it as a measurable quality of delivered care, it is more informative to understand it as a process, to be more specific, the creative process of justification work between doctor and patient. Such justification work is often non-linear, sometimes produc-

45 A suitable method for this could be for example video reflexive ethnography (Iedema et al., 2019).

ing conflicting meanings of what patient-centeredness entails in one and the same consultation. More important than finding what it actually is in the world or how to objectively measure it is to reflect on such creative processes in collaboration with professionals themselves. What do they do to achieve durable decisions? Knowing what goes well, how can they use it more structurally, thus improving how they deliver care patient-centeredly? More important than distributing questionnaires that enquire into a predefined checklist of patient-centered experiences is also, in this case, to train Primary Care Plus specialists to become aware of how they do patient-centered care. How do they feel out, deal with and make space for the diversity of moral convictions about what good care entails. Such a training would not entail practicing how to follow instructions, models of good patient-doctor interactions, or learning how to apply a protocol in diverse situations; it would depart from the professionals existing skills and competences in dealing with patients in the consultation room, reflection on what was done well there and then, comparing with others, and, from reflecting on it, find points of improvement and lessons for others.

The third promise I identified is that offering specialist consultations in a primary care setting would assist patient and specialist to take fewer unnecessary treatment decisions. As such, Primary Care Plus was promised to have potential for reducing health care costs. This potential was explained by contrasting the lean Primary Care Plus centers with the bureaucratic giants with huge overhead costs that hospitals have become. More importantly, in a primary care setting, rather than aiming to go to the bottom of the problem, specialist and patient would tend to think more like general practitioners: not doing more than feeling out whether there is a serious problem that needs more advanced specialist care or not.

The way in which Primary Care Plus and its mechanism of cost reduction are conceptualized in the third promise resonates with the policy tool of nudging. A nudge is a subtle change in the choice architecture, assisting people in taking the right choice. When nudging was presented as a new and promising policy tool, an alternative to banning options or directing people through informing them about benefits of making the right choice or the disadvantages of making the wrong choice. Nudging would help people to get on the right track without the risky and tiresome process of convincing them about what is right and wrong. After its introduction, an ethical debate took off, focusing on the question whether or not nudging, as a tool that bypasses the rational capacities of people, is detrimental to the autonomy of nudgee or not. Proponents of nudging have formulated two general answers to rebuke the critique. First, a nudge is merely a nudge; it is always possible to go against it. Secondly, a nudge merely nudges a nudgee in the direction that would make her better off according to her own standards.

Again, the promises of Primary Care Plus and the argumentation of proponents in the debate about the legitimacy of nudging is stuck in a representational idiom that does not do justice to the rich processes of justification work that unfold in the consultation rooms of Primary Care Plus as a nudge. I argued that tracking the work conducted to achieve durable decisions showed that two crucial assumptions of proponents are untenable. First of all, behind the actions of an agent there is not a set of “actual preferences” that actions are or are not an expression of. Preferences are not given beforehand; they come into being in the rich process of justification work that unfolds between the material and human agencies in the consultation room. Secondly, autonomy is not something that an agent possesses and that needs to be protected, it is the interactive process of justification work, in which the autonomy of doctor and patient is shaped. On the basis of the found process of achieving durable treatment decisions, I argued that the process of designing a nudge as well as the decision making in consultations is a process in which autonomy, preferences and the design of the nudge itself are subject to change. A more workable criterium is that for such an intentional modification of the choice architecture to be legitimate, it should not bypass processes of justification work but either generate them or leave space for a diversity of moral convictions about what good care entails. This could be done by refraining from placing “the right” specialists at the center and keeping the unsuitable ones out, but involving also the ones that perform differently in the above mentioned reflection sessions. Taking specialists out of their usual work environment, as said, can be particularly fruitful, provided that they are seen as sources of insight into what Primary Care Plus could entail, instead of taking them as cogs in the machine that should be taken out if not performing as expected.

The legitimacy of Primary Care Plus, as the relocation of specialist care with the intention of directing behavior, depends not only on how much autonomy patient and specialist have in the moment of taking a treatment decision (are they allowed to refer to the hospital or not) but on how the intervention is assessed and managed. Changes in the choice environment, in theory, could bypass rational capacities, but in the studied practices, I mainly saw the rational capacities of nudgees being turned on. It is thus crucial to refrain from rendering such valuable and unexpected processes and opportunities invisible while focusing on referral rates as the predefined desirable outcome of the nudge. The outcome of such changes are unpredictable, because they intervene in a playing field in which meanings, preferences and conditions are subject to change. This makes it important to monitor the implementation of such a relocation because of the unexpected problems. However, monitoring should be done with an open-ended outcome. Otherwise, as became clear in the fifth chapter, implementing the change becomes an iterative process of slowly filter-

ing out deviant elements, which would be detrimental to the claim of allowing the nudgee to set her own course.

In each of these practical implications, in one way or the other, the importance of creating space for, explicating and becoming skilled in feeling out and conducting knowledge and justification work is of central concern. The findings of the dissertation have implications for how we assess health care innovations. One of the central messages is that we should use open-ended methods more often that not only focus on the outcomes but also on the processes unfolding. With other words, instead of merely measuring outcomes, we should exnovate. Another related one pertains to the knowledge and justification work I tracked in the dissertation. Such work is thus not only important for the sake of making processes of health care delivery and management run fluently but also to enhance reflection and learning processes. A good doctor does not only make the correct diagnosis and selects the right treatment; she is also skilled in developing new routines of justification work to deal with constantly emerging and reemerging problems of patients dealing with a diversity of problems that are not merely social, trust-related or medical, but all three at once. Similarly, professionals need to be skilled in knowledge work in order to contribute to well-running organizational processes. Here as well, a good professional is not preoccupied with aligning the existing problem, justification and solution realities but in shifting from one knowledge world to the other, finding a common course of action, while giving space for heterogeneity. Such skills cannot be developed by reading books but by practicing again and again, viewing and explicating her own and others' processes of justification work that shape situated understandings of good care (management), i.e. it involves exnovation.