

Playing the Person Game in Healthcare

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Abstract

A 15-year intervention to better integrate medical and mental health care in a large multispecialty medical group is reviewed. This quest to heal the “mind-body split” in healthcare employs the metaphor of “creating a new game” to help clarify why this task has been so difficult to accomplish in most mainstream healthcare systems and to move existing change strategies to a new level. Integrating care is viewed not as a problem to be solved but as creating a “new game” that eventually becomes a “national pastime” played on “fields” all over the country. Casting current healthcare practice in the game metaphor, the mind-body split in healthcare is characterized as the “organism game” (biomedicine) running in parallel to a “mind game” (mental health), each with its own objectives, rules, players, tools, and playing fields. The problems of forced choice for patients and clinicians between these two “games” are reviewed and how these games are gradually being integrated into a “person game”, with biomedical and psychosocial factors well integrated by teams of physicians and mental health clinicians.

The Fragmentation Of Biomedical And Mental Health Care And The “Mind-Body Split”

Rene Descarte (1641) is commonly given credit for establishing separate domains for the physical and mental (or spiritual) and the philosophical basis for the “mind-body split”. In healthcare, this takes the form of separate and parallel systems for biomedical care of physical problems and mental health care of mental diseases and psychological conditions.

Over many decades, the old-time town doctor who did all of the above with limited scientific knowledge and tools has been replaced by dramatically more sophisticated and powerful medical knowledge applied by practitioners of many disciplines. What might have become a sensible and coordinated division of labor between biomedical and behavioral health clinicians in a world of exploding knowledge and know-how instead became mostly separate and non-communicating domains—each with separate clinical, professional, operational, insurance, payment, record-keeping and clinic siting practices. This paper focuses primarily on uniting the clinical domains, but touches on those other aspects as well.

Many persons need a well-coordinated blend of biomedical and behavioral care, especially those with chronic illness, industrial injury, psychosomatic or psychophysiological reactions, simultaneous co-morbid medical and mental health conditions, and ordinary mental health and psychosocial realities (such as family and vocational distress) that combine in a way that complicates many aspects of healthcare. The traditional either-or care delivery structure too often forces both patients and clinicians into a choice between medical and mental health: two kinds of problems, two kinds of clinicians, two kinds of care, two kinds of clinics, and two kinds of covered benefits. This either-or delivery structure exists even though most clinical presentations result from an interplay of biomedical and psychosocial factors that require a well-integrated blend of care. The authors (along with many others) have made this critique of healthcare system design elsewhere (Peek & Heinrich, 1998, 2000; Patterson, Peek, Heinrich, Bischoff & Scherger, (2002).

To someone outside healthcare, the problem may seem elementary and the solution obvious. Yet re-integrating biomedical and psychosocial aspects of healthcare delivery has typically been very difficult to do in the mainstream, even with increasing scientific evidence for it. Hence the authors, who have lived with and been puzzled by the difficulty encountered in moving forward this obvious idea, felt the need to look at the difficulty in a different way and take the reader through the following areas of our inquiry:

- Common dissatisfactions with the separate medical and mental health “games” in healthcare
- How the literature base has (and has not) led to change
- Metaphors in use in healthcare and how adding the game metaphor helps us understand why this change has been so difficult
- The story of the spread of the “person game” in one organization
- What the authors would have done differently had they been smart enough to incorporate the game metaphor from the beginning.

What’s Wrong With Separate And Parallel Systems For Medical And Mental Health Care?

The legacy of the mind-body split in healthcare is unhappiness of one kind or another for all stakeholders, even when everyone acknowledges the huge gains in know-how and outcomes in both domains. Energy for widespread change can come from mobilizing these dissatisfaction with the status quo (Dannemiller & Jacobs, 1992). Yet people often habituate to chronic unhappiness with the status quo, not recognizing the causes until named specifically.

Naming the dissatisfactions in a public way that people recognize can help generalized and chronic discontent become attached to specific features of the status quo and then motivate the search for better alternatives—a better game. Early in the quest the authors articulated the common dissatisfactions that people experience while providing, receiving, or purchasing care in the traditional separate and parallel structures for medical and mental health care—what they experience as being no fun in the games people are presently playing (paraphrased below from Peek & Heinrich (2000); Patterson et al (2002). Readers will no doubt recognize some of these from their own experience as patients, clinicians, managers, or executives. Articulating this common database of dissatisfaction with the status quo is intended to mobilize energy for change.

Common Clinician Dissatisfactions

1. You don't know enough about the complex patient sitting in front of you. Several charts all have just a piece of the story. One of these charts is not available, and the person with the information is on vacation.

2. Contacting other clinicians for more information is laborious or impractical. Schedules are set up for making referrals, not talking about cases first. Confidentiality and “phone tag” make it difficult to quickly find out what you need to know.

3. If you are a primary care doctor, you have to “sell” behavioral health referrals. Many patients see their problems as purely medical. You don't know the behavioral health clinicians or what they do or who to recommend. Mental health referral seems like a “black hole”.

4. If you are a mental health professional, some patients say, “I don't know why I'm here—my doctor sent me.” Others may say, “My doctor said you will do X with me”, but this prescription doesn't sound right and you don't want to unsettle the patient or undermine the doctor by immediately questioning it.

5. Many patient problems don't fit neatly into “medical” or “mental health” domains. If you are a physician, emotional factors can be difficult to address in a 15-minute visit, e.g. for headache, low back pain, somatization, or distress for families coping with chronic illnesses. Moreover, some patients keep coming back even when you feel you don't have anything left to offer, and you find yourself ordering another test or referral but have the feeling you aren't getting to the real issues. If you are a behavioral health clinician and the patient focuses on physical problems, you don't really know what to make of it (and it's not so easy to find out).

6. Complex situations that don't fit separate mental health/medical systems “can ruin your day.” Some patients complain about their physician to their therapist and vice-versa. It takes much less time to refill the pain medication or time-off prescription than to confront

complex problems for which you need a team. It is laborious to push the creation of a new team for every new situation that arises, so you just tough it out alone. When you see a certain name on the schedule that requires things you can't deliver all on your own, you want to go home.

Common Patient Dissatisfactions

1. ***“I’m physically ill but they think its all in my head.”*** At other times, patients ask, “When will someone take seriously how my personal stress and fear affects my health?”

2. ***“The left hand doesn’t know what the right hand is doing”.*** The patient may have a family doctor, a specialist or two, a psychiatrist, a therapist, and a group therapist, and say, “they keep sending me from one person to the next, and I repeat the same story over and over to every new person. No wonder health insurance is so high!”

3. ***“It seems like I’m at various doctors all the time and still not getting better.”*** The patient may say things like, “I get the feeling I’m not being a good patient and no one wants to see me anymore” or “It seems like they are trying to cut me off”, or “I get the feeling everything is my fault or maybe everything is their fault.”

Common Care System or Health Plan Dissatisfactions

1. ***Thick charts with high and unfocused utilization.*** Outpatient physician and behavioral healthcare visits multiply when delivery services don’t match clinical needs. Lots of “searching” and unnecessary visits result—along with unnecessarily high hospital and referral costs when a break in continuity of care occurs at the wrong time.

2. ***Patients who are often unhappy with care, even though they get a lot of it.*** Some of these become “difficult” patients only because “most difficult patients started out merely as complex.” A few patients resort to “doctor-shopping,” writing letters trying to secure help, bringing Internet solutions, or employing difficult behavior to make something better happen. But these strategies escalate conflict and tend to make

things worse for them.

3. *Misunderstandings occur between medical and behavioral health providers.* Common sources include limited understanding of what the different professions can contribute to the entire care of patients, “culture clash” from different ways of training, knowing, talking, thinking, and working, and pejorative mutual stereotypes based on limited contact and opportunity to work out problems.

4. *The problems of separate and parallel medical and mental health are no longer acceptable as a normal cost of doing business.* Care systems can no longer postpone redesigning basic care processes to improve total system quality and reduce the satisfaction and service penalties associated with healthcare that is fragmented along the medical-behavioral health split.

Common Employer Dissatisfactions

1. *Traditional behavioral healthcare may be seen as an expense of dubious value.* This is felt at times when it is difficult to see how mental health benefit dollars are contributing to health and good work adjustment, disability management and getting people safely back to work.

2. *Employers witness productivity or citizenship problems with some employees who will not seek behavioral healthcare for their mental health or substance abuse problems.* Employers already know that general medical settings are the most common place people seek help for symptoms associated with mental health and substance abuse problems. Employers also know that most primary care practices are not geared up well for detecting and treating these problems.

3. *Employers know that psychologically distressed employees are more often absent, get back on their feet more slowly, or fall into disability.* In addition to these employer burdens, these employees cost more in health benefits, whether their distress is “a covered mental health benefit “ or not. Ordinary marital and family distress is usually not covered by mental health benefits but is often brought to personal

physicians in some form and is identified by employers as a major cause of employee psychological distress.

As the reader can see, the root problem giving rise to these dissatisfactions is the “either-or” care delivery structure, not behavioral health problems or the patients themselves. What is commonly perceived in clinical practice as difficult in care of patients with intertwined biomedical and psychosocial problems is greatly magnified by a care system that typically fragments that care by first attempting to divide it into artificially separate domains of the organism and the mind.

How the Literature Base Has and Has Not Led to Change.

The dissatisfactions above have been accompanied by a huge literature on the interplay of biomedical and psychosocial conditions and how care systems and individual clinicians, managers, and insurers can take this interplay into account more effectively. Published research and demonstrated models for integrating biomedical and psychosocial healthcare have been recommending a more integrated approach since the 1960's. Since then, particularly since the 1990's, a flood of books, articles, conferences, demonstration projects, government reports and task forces have recommended the integration of medical and mental health care in many contexts and for many reasons. But as of 2005, integrated medical and mental health care still awaits mainstream implementation, even though the ideas are now largely accepted and many local, state, or agency level recommendations and demonstrations are taking place.

It is no longer necessary to raise consciousness and sell the concept. It is now necessary to help real clinicians, patients, care systems, health plans, and policymakers make fundamental changes in actual practice “on the ground” and gradually improve them until a practical integrated system emerges. The literature is enormous and cannot be reviewed here. The reader is referred to the following books just since 1992 that include literature reviews: Haas (Ed., 2004), Frank, McDaniel, Bray, & Heldring (Eds., 2003); Maruish (2000), Patterson, Peek, Heinrich, Bischoff & Scherger (2002); Cummings, O'Donahue, & Ferguson (2003); Seaburn, Lorenz, Gunn, Gawinski, & Mauksch (1996); McDaniel, Hepworth,

& Doherty (1997); Cummings, Cummings & Johnson, (Eds.,1997); Blount, (Ed, 1998); Haber & Mitchell (Eds., 1998). More books are currently in press and hundreds of separate articles and chapters in other books or Task Force reports are in print.

The literature frequently points to the difficulties in making the change to an integrated system of medical and mental health care. But the difficulty achieving mainstream progress puzzles many who have worked for this change over the past forty years. This paper offers a way to look at and appreciate the enormity of the challenge of integration by looking at it fundamentally as a matter of inventing and then attracting people to “a new ball game”.

Metaphors in Healthcare

Common metaphors in use

Metaphors develop spontaneously around complex human activities as people discover patterns and similarities between one field or activity and another. Apt metaphors can help people relate new or complex fields to things they already understand and can create handy images and figures of speech that guide action. Healthcare is no exception. Some metaphors found in healthcare are comparisons to other fields (real metaphors) and others are different perspectives from which to view healthcare (not so much metaphors as perspectives or viewing angles). But for purposes of this paper, the following five metaphors serve the same function—to facilitate understanding of underlying patterns and creation of a useful set of images or heuristics for planning, acting and evaluating actions going on in a very complex undertaking:

- Science
- Engineering
- Business
- Politics
- Community

Each contributes different insights and images to healthcare and has a different range of useful application. Taken together they are a useful package of metaphors when used at the right time for the right purpose. They don't so much compete with each other as fill out the whole metaphorical toolbox. No single one could possibly do the job by itself and the point is not to pit one against the other, argue for the superiority of one over the others, but to know when and how to use each one.

Science. This is not so much a metaphor as a key perspective or viewing angle, particularly for the clinical dimension of healthcare. People speak of “evidence-based medicine”-- providing care that works and avoiding care that doesn't work; taking a scientific mindset to the understanding of health and illness; and creating effective treatments through scientific methods. A scientific mindset is also present in creating “patient centered care” where the evidence-basis for patient-clinician communication and relationship-building is the focus. A scientific mindset also accompanies much quality improvement in healthcare, with concepts and tools such as “small tests of change”, “process measures”, and “run charts”. Knowing science helps you know healthcare.

Engineering. This metaphor is a close cousin to science, particularly for the operational dimension of healthcare. This mindset appears as process improvement, office practice improvement, continuous quality improvement (CQI) or total quality management (TQM); patient safety as in “safety is a system property” (Institute of Medicine, 2000) or “best practices”; coding, billing, and charting systems, and the design of human resources (HR) and performance management systems. The engineering metaphor invites us to look at healthcare as a system that can be designed and built consciously and well from basic design and manufacturing principles and practices-- rather than being informally and inconsistently patched together over time. Knowing engineering helps you know healthcare.

Business. This perspective is a cousin to engineering, also relying on explicitly designed systems, measures and benchmarks that use numbers. But it focuses primarily on the financial dimension of healthcare-- staying

solvent, making the best use of resources, and building market position. This brings with it talk of markets, market share, competitive edge, territory, the right price and value, consumerism, margin and bottom line, reserves, risk exposure, capital investment, contracting, fee schedules, cost structure, regulatory compliance, business ethics and so on. This perspective brings a language and mindset for using established business principles and industry standards for survival in a competitive and risky world. Knowing business helps you know healthcare.

Politics. This perspective, a next-door neighbor to business, has internal and external application. Internally, the political perspective has to do with who is at the table, who gives input and how meetings are run; who ultimately makes decisions; how general buy-in is obtained; and the internal distribution of risks and benefits, perks and prestige. This perspective brings talk of organizational structure, governance, process, organizational culture, internal communication and feedback loops, and helping everyone find their way to contribute to the enterprise and discover their motivation to do so.

Externally, the political perspective has to do with the rules of the game on national, state, or local levels; where key issues for healthcare are raised in the public sphere and by whom, who takes which risks, mutual responsibilities among stakeholders, how decisions are made, proper regulatory compliance, appropriate legal and business structures, and so on.

Both the internal and external political metaphor or perspective bring with them talk of constituencies, knowing what matters to whom, lobbying, jockeying, negotiating, bargaining, clout, influence, leadership, and so on. Sometimes when things are intense, the metaphor shifts to war— with talk of battles, fronts, turf wars, shots fired, ground gained, blood let, industrial espionage, loyal soldiers, etc. Or a sports metaphor might take hold—with talk of moving the ball forward, scoring, blocking, curve balls, changing the playbook, hitting a home run, being benched, cheer-leading, high-sticking, penalty box, and so on. Knowing politics, war, and sports helps you know healthcare.

Community. This metaphor is much less common in healthcare, even if it has equal or greater intuitive appeal as discovered by the authors who have featured this metaphor in their own organizational leadership and consulting since 1991. In this metaphor, the healthcare organization (defined as tightly or loosely as you wish) is compared to a community—more than that—a “community with a mission” (Putman 1990). This is a group of people who recognize each other as a more or less defined group dedicated to a common purpose—along with a set of shared practices, decision making principles, concepts and language, and a particular world or sphere in which they operate together. This metaphor brings talk about community and community-building, shared mission, members, what members do together (practices), what is real to them (concepts and language) how they structure their thinking and actions (decision-making principles), and how they construct and delimit the world in which they operate (in this case, the clinical, operational, and financial worlds of healthcare).

The community metaphor leaves room for the language of all the other metaphors—in the concepts, language, practices and decision-making principles of the community. This is a major advantage for a healthcare metaphor, because members of the healthcare community (taken together) do in fact need to be able to think as scientists, engineers, business people, politicians, and keepers of a human community. Knowing community-building also helps you know healthcare.

Why Add the Game Metaphor?

With all these healthcare metaphors or perspectives already in use, why add another? Why introduce the language of games to an already-busy metaphorical landscape? Why introduce a game metaphor when healthcare is by no means playing around or a laughing matter?

The reason is this: The game metaphor makes it very difficult to avoid confronting the deeply human challenge of getting healthcare people, systems, and patients to change what they do everyday—to question their deepest traditions and change time-honored rules of the game that they grew up to assume and respect—and perhaps not even question. The

game metaphor makes it impossible to slide around the fact that there may be a new game in town, but few people want to play it. Why not? And what can we do about it? The rest of this paper explores this.

If change in healthcare is seen purely as a science topic to entertain, an engineering challenge to meet, a business problem to be solved, or a political situation to be negotiated, the core human challenge of changing deeply held patterns is scarcely recognized for what it is, let alone addressed. The fact that healing the mind body-split in healthcare has a forty year long trail of scientific, engineering, business, and localized political effort—but still exists only in pockets-- speaks to the fact that something is missing in the human analysis. We hope the reader will follow us as we look at our own quest for integrated medical and mental health care through the lens of “games we play in healthcare”. The game metaphor is of course anchored in the community metaphor described earlier, but brings with it familiar language and imagery—along with an intuitive appreciation of what it takes to create a new game that people actually want to play. We believe that thinking about games also helps us understand healthcare.

What The Game Metaphor Opened Up

Adding the game metaphor opened up to the authors a new set of images and language in a familiar idiom to help describe the stubborn challenges in healing the mind-body split in healthcare. In this view, better integrated care means establishing a new game with new goals, players, and rules for clinicians, patients, and care systems. This means integrated care would need to be a team sport—not an individual competition or a form of solitaire. Moreover, it means creating a team sport that is *widely* practiced, rather than practiced only in isolated pockets among a few collaborative care pioneers. From this, several often-overlooked insights quickly emerged:

Integrated care is not a problem to be solved—it’s a creation. Better integrating biomedical and psychosocial care isn’t just a scientific problem, a clinical problem, business problem, an organizational problem, or a political problem to be *solved*. Rather, it is a human *creation*—*cre-*

ating a “major league” new social practice or “game” within local, then larger, healthcare *communities*. The task of healing the mind-body split in healthcare is no less than creating a new game in healthcare and seeing it played all over town by just about everyone—“the only game in town”.

But efforts to better integrate biomedical and psychosocial healthcare have often treated it as a clinical, scientific, communication, or business problem. Technical solutions or adjustments are applied to the old ways, e.g., better research-based protocols, improved systems for information exchange, or adjustments to things like coding and billing systems, healthcare benefits design or contracts, geographic proximity of clinicians, social mixing, cultural understanding between professionals, or exhortations to collaborate and communicate better.

While these problem-solving steps are certainly necessary and often do improve the level of coordination and collaboration between medical and mental health clinicians, they often fail to gain widespread and enduring acceptance in the mainstream of care systems and professional communities. The missing ingredient is the conscious effort to invent and spread *a new game* in town. This has to do with people’s daily practices and relationships—what they show up on the field to do every day, who they do it with, how they equip themselves to do it, and how they measure themselves (their own “player stats”). Conventional problem solving is aimed at improving play of the old game, but rarely makes a frank call for a new game. The problem-solving approach, especially when genuinely helpful, can actually postpone the day of reckoning—the realization that the old separate and parallel model for biomedical and mental health care delivery is just not salvageable in the long run.

The game metaphor reminds us of that missing piece: that mainstream integration of biomedical and psychosocial healthcare today is about shifting world views and daily practices of clinicians, along with operations and finance experts, “in here, among us”, even more than about technical or scientific issues “out there”. The enabling factor is not so much problem solving as what in Descriptive Psychology is sometimes called world reconstruction (Roberts, 1985) and what is real, who I show up as, what

I pay attention to, my place in the story, what I do with whom as an actor, observer, or critic, and the rules of the game or social practices (Putman, 1998, p 129-137; Ossorio, 1998, p. 104). The game metaphor gives intuitive access to this in a way that “problem-solving” does not. Hence we speak first of “bringing a new game to town” rather than “solving a slate of problems”. Creating a new game in town is much tougher in human terms than solving a slate of technical problems with the old games.

Most new games never make it beyond their inventors. This reminded us of our experience with integrated care. Many demonstrations in integrated healthcare prosper while under the personal guidance of founders and pioneering figures, but dissipate in the press of usual practice when these figures move on. The game metaphor makes it easier to understand why progress in this area in the national sphere has been slow and prone to setbacks. Ask yourself how many of the games invented by people over the ages end up being played daily on the world’s stage? How many of you invented games as children? But how many of these lasted beyond your own childhood group? For every game that reaches the stature of baseball, chess, GO, or Monopoly, how many others were invented but died with their inventors or occupied a niche only to be swept away when the niche was? This is the familiar problem of creating a next generation of leaders for innovative practices and creating “games” that people really want to play even after the charismatic founders are no longer cheerleading and marketing them.

Without really knowing it at the outset of their journey, the authors had set themselves the daunting goal of inventing and spreading a new game in healthcare, starting in their own organization.

Mainstreaming integrated healthcare means turning “pickup games” into a “national pastime”. The challenge to pioneers, advocates, and champions is what quality improvement experts call “spread”—allowing the most successful experiments, demonstrations, and successful tests of change to become routine practice everywhere. Staying with the game metaphor, this means turning the many spontaneous and improvised “pickup games” played by collaborating clinicians into a “national

pastime” rather than letting these remain invisible exceptions in the background or die away with their local founders. The goal is to help unorganized groups of a few people who integrate care become a much larger community of many players across the many professions. This much larger community of clinicians and patients will need to be joined by large organizations and insurers who sponsor these activities and also play by the new rules. As mentioned earlier, Putman (1990, 1998) captures this idea as “an organization is a community with a mission”. In this view, building organizations is largely the work of building organizational and professional communities. This Descriptive Psychology formulation of organization and community has been core to the authors’ approach to organizational and professional change and therefore is one of the health-care metaphors listed earlier.

After seeing the integrated care challenge more clearly, the authors playfully adjusted their mission to read: “When it comes to better integrated medical and mental health care, there shall be a new game. And there will be requests for more and more games, by more and more players, with better and better equipment, teams, parks, and leagues.”

New games are most marketable when interesting enough, simple enough, compatible enough with related games, and available for a free trial. These are lessons from the “diffusion of innovation” literature discussed in more detail later (Rogers, 1983) but put in way that is less technical and academic sounding. This literature identifies things empirically associated with successful widespread implementation of new methods, i.e., distinct improvement over usual practice, compatibility with everything around it, simplicity, potential to try it first, and observability of the results. The game metaphor complements the diffusion literature by casting it in more accessible and personal terms as the marketing of a new game in town to replace old limited ones.

Both the game metaphor and the diffusion literature leave a place for mobilizing energy for change from the previously outlined dissatisfactions real people have in playing the existing games— what people don’t like (but often stoically accept)—and what game would attract more

players. Mobilizing large-scale dissatisfaction with the status quo as the driving force for a new vision and first steps is discussed by Dannemiller & Jacobs (1992) and a case study in healthcare by Peek, Heinrich, & Putman (1997).

At this point in the chapter, we will go ahead and use the game metaphor consistently, anticipating that the reader will see some of the same advantages we see. However, this does not mean we are trying to displace the science, engineering, business, politics, community or other healthcare metaphors or are merely suggesting a new way of talking about everything. We certainly don't go around talking about everything as a game. Instead, we are trying to show what additional mileage is to be gained with the chronic issue of better integrating medical and mental health care by applying the game metaphor in a few key areas.

The Games People Play in Healthcare

One way to mobilize energy for change is to cast the unsatisfying features of usual practice as “rules of the game” now being played. This device can make it easier to see how usual practice does not handle the clinical reality that we face every day. Making these connections is especially important when people have become habituated to the consequences of the old games—and accept them without thought as “a normal cost of doing business.”

The Organism, Mind, and Person Games.

Table 1 shows “the games we play in healthcare”. This is a heuristic device rather than a literal depiction of reality. The first two columns (organism game and mind game) highlight rules or premises of the separate and parallel approaches to biomedical and psychosocial health care. The third column (person game) outlines new rules of a new game in which the old games are realistically combined.

Table 1. The games we play in healthcare

	Organism game	Mind game	Person game
Object— what you touch every day	The disease and disease processes—physical pathology	Mental processes and constructs—psychopathology	The unfolding life of a person, in context of disease and illness (see next table for this distinction)
Core approach	Treat patients as mindless bodies (except when the mind is really just an another body part)	Treat patients as body-less minds (except when the mind is just another organ of the body)	Treat patients like person—persons who lead a life and make mindful (or not) choices every day while inhabiting their bodies
Players	Physicians and other biomedical clinicians, usually as soloists	Mental health professionals, usually as soloists.	Healthcare professionals, regardless of professional discipline, often in teams (no one knows everything)
Root concepts and language	Physical & biological science with a nod to social sciences when necessary	Psychological theory, with effort to use methods of science, especially the biology of mental illness & behavior	Based in biopsychosocial concepts, self-determination, and goals of care as defined by the person. Still evolving a broad base of quantitative and qualitative science
Object of game	Fix the organism, or at least keep it going and prevent its death	Cure of the mental disorder (or at least management)	Help a person improve/maintain health, manage health conditions, realize individual/family goals of care; retain meaningful participation in the community throughout life and end of life.
Role of clinician	Find and fix	Find and explain—hopefully fix	An invited expert, coach, trainer and guest in the patient’s life—along with “finding and fixing” where possible
Measures or stats	Physiological measures, lab values, disease state indicators, your own outcome stats	Presence / absence of diagnostic signs / scores, mental symptoms & functioning	Ability to participate with satisfaction in the life of the community, including ability to monitor and manage conditions & symptoms that would significantly interfere with it

To keep it simple, this was done in a stereotypical, simplistic, and irreverent or satirical way that hopes to engage people in recognizing the foibles in usual practice—as honorable historical facts rather than threatening people or making them rise to a defense. The purpose of this device is not to educate, convince, criticize, or pressure, but to crystallize motivating insights and stimulate curiosity. In Descriptive Psychology, this amounts to mobilizing the person's *own* “critic function” to arouse the curiosity needed to question things without making the person feel defensive or bad. This table employs deliberate stereotypes and irreverent oversimplifications just for the sake of illustration!

Some readers, particularly those from outside healthcare, will see the problem and solution depicted here as painfully obvious and wonder why there needs to be a paper devoted to it. But from the inside, the legacy of separate and parallel systems is so strong that it takes more than exhortation to mobilize change—as if the traditional games command so much loyalty that they survive in the face of obvious deficits in handling daily reality. Hence pointing out the foibles of the traditional games and offering a new one is a promising strategy for change and is consistent with the diffusion literature (offer something distinctly superior to usual practice).

Much of the dissatisfaction with the separate and parallel organism game and mind game is traceable to patients shuffled (often out of desperation) between biomedical and mental health clinicians who are playing their separate games on separate fields. Patients are often unhappy with both games encountered in the healthcare system. “Why can't they treat me like a person, not just an assembly of separate physical and mental problems!” The person game does just that—by combining the best goals, strategies, and plays of both the organism and mind games. In this game, the same patient is viewed from biomedical and psychosocial perspectives and these are combined into one picture.

This can be compared to ordinary binocular vision. One eye sees an object from one perspective and the other eye sees the same object from a somewhat different perspective and our brain combines these visual in-

puts into *one* picture of *one* object with amazing perception of depth that neither eye could accomplish alone.

Treating a Disease; Treating an Illness.

Table 2 follows up with a contrast between “treating a disease in an organism” and “treating an illness in a person”. The therapeutic moves are different for treatment of an illness because social and family factors, poverty, what people bring to their diseases, and what counts for them as meaningful living are all incorporated. This is shown below, again in simplistic stereotypical form as an illustrative device rather than a literal portrayal. Of course, in reality clinicians work in both these modes because the disease is present in the illness. Illness care goes beyond disease care, but does not neglect it.

Note that the same contrast between disease and illness can be drawn for mental diseases—those of the brain or the intrapsychic mechanism contained in the theory the therapist is using. In addition, psychiatrists, psychologists, or others sometimes recast mental processes as biological processes in order to connect mental health phenomena with the growing biological science base.

In the end, patients want to be treated like persons who are also organisms—and want their clinicians and care systems to have the wisdom to know the right time and place for each way of thinking and how to blend them into one approach.

Table 2. Treating a Disease and Treating an Illness

	Disease (of an organism)	Illness (disease played out in a person)
Basic questions	What are the mechanical breakdowns, physical findings, or loss of physical function? What is the fix or management strategy?	Where is the disability and interference with being a person in a community? How can effective care of the disease be successfully incorporated into the life of the person?
Object— what you touch every day	Bodies, protoplasm, organs, organ systems, organism	Life in a community, including limitations, sensations, and self-management challenges imposed by bodily realities and conditions
Process	Find and fix—or establish strategy for damage control	Coach on incorporating physical realities and conditions into daily life while “fixing” physical conditions where possible
Desired outcome	A body free of disease, in remission, or controlled	A person living what they consider a good life as a member of a community (patient-centered care). Maximum behavior potential and participation in the practices of the community
Standard	Normal or best-you-can-hope-for physiology, medical indicators and functions	Doing as well as you can expect a person in that situation to do with those conditions present in their life.
Dr-Patient Relationship	Educator-educated, fixer-fixed	Interviewer/listener-storyteller/synthesizer Coach-actor
Relevant principles	Science, healing, ethics; safe and effective (evidence-based medicine) procedures and conduct	Science, healing, ethics; Safe and effective coaching in participating in the life of communities, given health problems

Pathology and a Person-centered Approach

The Descriptive Psychology definition of pathology (Ossorio, 1997) makes clear why a blended, person-centered approach that emphasizes participation in the social practices of communities appears so promi-

nently in the “illness” column above: “When a person is in a pathological state there is a significant restriction on his ability. . . to participate in the social practices of the community”. Paraphrased in the vernacular, this becomes, “A person is sick when he is sufficiently limited in his ability to do what is essential to being a person, i.e., act on purpose in ways that make sense, knowing what he is doing . . . or to do what a real person in a real life setting ought to be able to do” (Ossorio, 1997, p. 11).

This definition of pathology applies equally to problems such as a broken leg or major depression. In both cases, the person’s ability to participate in the social practices of the community is significantly impaired, and that is how you know they are really sick. This definition makes the restriction of behavioral capabilities essential to the notion of illness of any kind, as shown in the following thought experiment (Ossorio, 1997, p.15):

“Imagine that I have a broken leg or an extreme case of gout or arthritis affecting my legs. Imagine also that, nevertheless, I am able to do all of the things I used to be able to do before I had this condition. That is, I can walk, run, hop, kick various objects, climb ladders, dance (and enjoy it), and so on. Moreover, this state of affairs can be expected to continue indefinitely. And finally, imagine that I am not exceptional in these respects, but rather that I am typical of people who have broken legs, gout, or arthritis. Under these conditions, would I or anyone else claim that I was “sick?” Obviously not—it would be nonsensical. Yet such physiological conditions are what we routinely and unreflectively refer to as the illness. What the thought experiment brings out clearly is that it is the restriction in behavioral capabilities which is essential to the notion of illness, because without that there is nothing to be explained by reference to a physiological, psychological, or other condition, and there is nothing that calls for treatment by reference to physiological, psychological, or other theories.”

Because all illnesses may be conceptualized in this way as restrictions on a person’s ability to participate successfully in the social practices of his or her community, treatment of the person must focus on how these

restrictions can be removed or how the person can live with those that are unalterable. Such a conceptualization provides the basis for the person game or “person medicine” with a wide range of “biopsychosocial” interventions, a famous term coined by George Engel in germinal writings that proposed a model of human health and illness that combines interacting biological, psychological, and social dimensions and contributing factors to health or illness (Engel, 1977, 1980).

Reconciling “Evidence-based Medicine” with “Patient-centered Care”

Before returning to our own story, we want to lead the reader through a key discussion taking place right now in healthcare that illustrates and reinforces the importance of a shift to “the person game” that prominently includes patient behavioral capabilities as members of communities. Two seemingly opposing but powerful and simultaneous trends in healthcare (“evidence-based medicine” and “patient-centered care”) are calling out for reconciliation. Each of these has its own rules and could be thought of as competing games in healthcare. This is summarized very clearly by Jozien Bensing (2000). We will draw from Bensing’s article and offer a way of thinking about it that incorporates both into what we call “person medicine”. Bensing opens with this statement:

“Modern medicine is dominated by two general beliefs or paradigms: one is called ‘evidence-based medicine’; the other is called ‘patient-centered medicine’. Both concepts are generally accepted as ‘good’, ‘valuable’, and something to strive for. Few people will deny the relevance of either of them. But two serious questions can be raised. For, how patient-centered is evidence-based medicine? And, how evidence-based is patient-centered medicine? Close inspection of the literature reveals that evidence-based medicine and patient-centered medicine seem to belong to separate worlds. Bridging the gap is a major challenge for all who want to protect the humane face of medicine in the next millennium.”

Evidence-based medicine. Summarizing from Bensing, evidence-based medicine is often biomedical and positivistic in perspective, relying on a highly developed empirical base from homogeneous patient

groups with the same condition in randomized clinical trials. It relies on evidence for the most adequate treatments in health care, often on meta-analyses or review studies of the best randomized clinical trials, along with strength-of-evidence scales as way of knowing how heavily to weight particular studies.

Evidence-based medicine is disease-centered—with best care of diseases at its core. In this way it can be regarded as “doctor-centered”—the doctor’s interpretation of the evidence with diminished attention to the patient role and the patient’s own relationship to the condition in the context of life. It holds out the promise of ideal integration of individual clinical expertise and external scientific evidence, producing guidelines, protocols, and standards that serve as a professional group decision that are sometimes offered as an alternative to individualized patient decisions. In this way, evidence-based medicine is considered hard and objective, rather than fuzzy and subjective.

Patient-centered medicine. Patient-centered medicine is humanistic and biopsychosocial in perspective, holding out promise of successfully applying evidence-based approaches to real patients, focusing on the care of illness as well as the treatment of disease. It is concerned with facilitating patients’ disclosure of real needs, wants, and worries, emphasizing patient participation in decision making by taking into account the patient’s perspective, and tailoring medical care to the patient’s needs and preferences. Knowledge from individual patients such as their own experience, capacities, needs, preferences are considered to be important additional sources of information.

The theoretical, values, or relational basis is more highly developed than the scientific evidence base, centering on the naturally-occurring diversity of problems and individuals in clinical practice rather than on homogeneous condition-specific populations. Patient-centered medicine is also concerned with the content of the consultation, the choice of topics that should, or could be addressed, control over the consultation, whose agenda is to be dealt with, and who is expected and has the power to make decisions. In this way, the evidence domain for patient-centered

care is patient-clinician communication research as much or more than homogeneous and disease-specific randomized controlled trials.

Bensing goes on to point out his surprise at the need to talk about “patient-centered care” at all:

“The very first thing that comes into mind when reflecting about the concept of patient-centered medicine is . . . bizarre and extremely important. . . that a concept like ‘patient-centered medicine’ exists. It is bizarre. . . because the term ‘patient-centered’ should be a superfluous addition to the term medicine. All medicine should—by definition—be patient-centered. However, it is not. Since Hippocrates told us: ‘first of all, do no harm’, medicine has developed as a scientific endeavour, as a technological challenge, as an organizational puzzle and as an economic enterprise, in which—undoubtedly—everybody will claim that everything that is done, is done on behalf of the patient, that—of course—the patient is the centre of it all. But, certainly, most patients won’t feel it that way.”

Bensing’s surprise that the concept of patient-centered medicine exists at all parallels the surprise from people outside healthcare that the task of integrating biomedical and psychosocial healthcare is a longstanding issue that still exists at all.

Bensing points out that the concept of “patient-centered medicine” is not firmly rooted in empirical evidence. It is regarded as a “fuzzy concept”—a global concept whose meaning everyone understands, but with quite different connotations for different people. “Fuzzy” also means that the core elements of the concept are clear to everyone, but at the edges the picture becomes blurred and difficult to operationalize with measurable elements— which of course is what researchers need to do. He concludes that “preparing patient-centeredness for empirical research means that the concept has to be clarified.” He goes on to do this by relating “patient-centered” to “doctor-centered” or “disease-centered” in a way quite similar to our contrast between the organism game and the person game.

Reconciling “Evidence-Based” and “Patient-Centered” as Aspects of the Person Game.

We suggest that these two powerful trends in medicine can be reconciled and placed under one conceptual and practical roof of “person medicine” or the person game through the use of two Descriptive Psychology contributions: A clear concept of “person”, and the notion of operating simultaneously from more than one framework or “world”.

Using the Descriptive Psychology person concept to reduce the “fuzzy” quality of the patient-centered concept. “Patient-centered” can readily be translated to “person-centered”, which more clearly points to treating patients like persons rather than a collection of independent diseases. Bensing points out that “patient-centered medicine” is a global concept with core elements that are clear to everyone, but blurred at the edges and difficult to operationalize with measurable elements. Such a picture is blurred to the extent that the concept of “person” is blurred.

Fortunately, Descriptive Psychology has a very clear and systematic formulation of the person concept (Ossorio, 1995), one that permits clinicians to distinguish and orient to important factors in patient-centered healthcare such as:

- Community practices that are most important to that person; what the person most wants to be able to keep doing
- Valued places or roles in their various communities that the person wants to maintain.
- The person’s own view or theory about their disease and health—and the significance to that view of various alternative choices of medical care.
- Embodiment—all the facts and conditions of the physical organism that affect what a person can do or will likely be able to do in the future.
- The person’s own story and world within which disease and health have a place, including the person’s own concept of living a good life and dying a good death

- A person's decision-making principles or spiritual practices relevant to health decision-making
- Anything else that characterizes a person and their actions.

With a well-articulated person concept in place, patient-physician communication goals and practices can be systematized such that care of diseases and conditions is carried out in a person-centered manner that is much less fuzzy. To the extent that particular interviewing or relationship-building strategies are found empirically to be productive increases the scientific evidence basis for person-centered care. Furthermore, the Descriptive Psychology person concept does include embodiment—a place to take into account organism facts as an aspect of the person. All this is for a different paper!

Evidence-based and patient-centered paradigms as mutually influential and simultaneous realities. There is no need to frame these as either-or or competing choices. Don't ask which is more important, which trumps the other, or which has the most solid foundation. Descriptive Psychology provides conceptual foundations for living and working in simultaneous realities or worlds such as this (Roberts, 1998; Jeffrey, 1998; Patterson et al, 2002). The fact is that we need to play “the person game” by both kinds of rules because the clinician's and patient's total world is composed of both the worlds of evidence-based medicine and patient-centered care. Principles for operating simultaneously in an evidence-based and patient-centered manner:

A. Do only what demonstrably works for the care of diseases and conditions (and not things that make no difference or cause harm) based in scientific study of which treatments work in general for given conditions where the clinical picture is not complicated by wildly interfering other conditions. (evidence-based medicine)

B. Apply these patterns of evidence-based care to actual patients with their full participation (to the extent they want it) and tailored to their multiple and interacting conditions along with their needs, wants, values, capacities, and preferences—with the relationship and communication

strategies that are scientifically shown to be effective when done well by clinicians. (patient-centered medicine)

In a nutshell, this approach can be captured in a pair of mottos for use in person-centered medicine:

- A. Do evidence-based medicine in a patient-centered sort of way, and
- B. Do patient-centered care in an evidence-based sort of way.

Advantages and Satisfactions in Playing the “Person Game”

Convincing arguments are needed to spread person-centered medicine. But beyond that, clinicians (and others) must experience actual advantages from playing the person game rather than the separate and parallel organism or mind games. These satisfactions are the flip-side of the dissatisfactions described earlier. Without concrete practical advantages to a new game, things tend to stay the same. A sample of advantages or satisfactions associated with the person game are listed below, using similar categories as the “dissatisfactions with the status quo” described earlier.

Common Clinician Satisfactions

The concept of illness and pathology matches what patients actually present, rather than leaving room mostly for the disease aspect. As shown in Tables 1 and 2, playing the person game in healthcare means attending to diseases and the psychosocial aspects of illness and health—including the person’s ability to participate as well as possible in the social practices of the communities in which he or she is a part. Whereas the separate and parallel systems for medical and mental health care tend to center on physical or mental diseases as the underlying pathology and focus of healthcare, person medicine (playing the person game) sees pathology as fundamentally linked to behavioral capabilities and limitations that come from disease processes. This expanded view more closely matches the picture that patients actually present to clinicians, what clinicians listen to and work with anyway, and what is required for good outcomes in actual practice.

Clinicians are equipped with roles, rules, tools, and team for actual clinical presentations they confront in daily practice. The clinician is not required by rules to first sort medical from mental health and then try to take on one portion while attempting to refer out for the other. Complex and intertwined biomedical and psychosocial factors in illness and health are allowed to remain intertwined in one person-centered picture, and the appropriate team is assembled for coordinated expertise in the various aspects of that one picture. Clinical, operational, and financial systems are designed to make this possible rather than putting up obstacles to a person-centered approach.

The person game can be a more satisfying “team sport”. Acting alone within your biomedical or mental health domain can be a frustrating individual sport. When individual clinicians are confronted by complex clinical presentations that they don't feel able to address alone, discomfort results. As the Descriptive Psychology maxim goes, “If the situation calls for a person to do something he *can't* do, he'll do something he *can* do, if he does anything at all” (Ossorio, 2002, p. 40). But if accessible and reliable teams are in place for these common complex clinical situations, clinicians will have something they *can* do in any situation, and will enjoy practice and appreciate their colleagues more.

The person game has greater potential for professional development and satisfaction. The scope of person medicine is broad and the interactions, strategies, and content are numerous and complex. The person game is indeed complex and has a long learning curve, but once you get the hang of it, the rewards are extraordinary. The person game comes with a much wider set of possibilities and “levels of play” for a lifetime of professional exploration and development. The decision to learn this game might be compared to the decision to continue with a typewriter vs. learning a word processing program. Everyone agrees there is a steep learning curve to computers along with many ways to become frustrated at first (and later on too). But virtually no one would go back to a typewriter once they get the hang of their word processing program.

Clinicians may actually be able to play the person game more readily

than they might initially think, because the person game taps into the full range of clinicians' competence as persons themselves. The person game in healthcare returns them to what they already understand about people and the ordinary language of health, illness, and healing-- but with all the clinician's technical training powerfully added to it.

Chronic care is less frustrating using a biopsychosocial approach.

Almost all chronic care, e.g., for diabetes, congestive heart failure, or asthma, involve multiple interacting factors that require a biopsychosocial approach with "prepared practice teams" using "integrated health information" to maintain "productive interactions" between clinicians and "informed activated patients" (quotes from Wagner et al, 1996). Such contemporary views of chronic care are heavily person-centered, even as they address disease processes. This is because chronic illnesses are managed, not cured, and a big challenge is patient self-management and health behavior change. Goals of care include helping the patient participate in the social practices of his or her communities. Addressing chronic care in this way makes it much more satisfying for clinicians and patients alike.

Rehabilitation, industrial injury, and back-to-work planning is less frustrating with the larger picture in view. These issues necessarily weave together social, vocational, and financial issues with physical and psychological factors. In a traditional mental health framework, back to work issues may be seen as an employer intrusion into the therapeutic relationship or as "non-clinical" or "administrative" concerns, when in reality work adjustment is a key area for health. In a strictly biomedical framework, the patient's fears, anger, mental health conditions, or personal situation regarding getting back to work may be seen as a Pandora's box that the clinician does not want to open, yet are key parts of the total picture. Complex psychophysiological reactions and emotional distress have the same features—an inextricable blend of biomedical and psychosocial factors that become much easier and more natural for everyone when clinicians treat people like persons rather than only organisms or minds.

Common Patient Satisfaction

Patients would like to participate in their healthcare as persons.

This goes beyond being treated merely as organisms or mental assemblies. They will help, rather than resist, when clinicians treat them as persons rather than as disconnected organisms or minds—so long as the organism and mind facts remain in the picture!

Clinicians more readily take into account the personal significance of medical or disease facts for the patient and family. When clinicians are thinking of health and health problems in purely organism terms or purely in mental terms, it is very easy to miss the significance of either mental or physical findings for the *person*. For example, anyone who has ever been sick or hurt knows that problems with the organism have significance for the person—sometimes profound ones. A biomedical clinician focused just on the physical findings may catch the *organism* facts, but lose their significance for the *person*. In this way, even a conscientious clinician can miss what matters most to the person, even when being very clear and accurate about a disease.

In the same way, a mental health professional may miss the significance of biological problems for the person, e.g., how an injury affects ability to engage in meaningful social practices of the community; how a work injury brings in back-to-work issues, employer concerns, worker's compensation and livelihood issues that are not traditionally thought of as mental health problems.

But the patient is aware of all these interconnections. The person game and its larger concept of pathology has an important place for all of it—mental, physical and social facts that have significance for a person's life, how they lead it, and how they are able participate in the social practices of their communities. Connecting patient self-management of diseases such as diabetes depends for success on linking behavioral changes to what already matters to patients, which is usually at the level of the person, not only the disease. This is important to patients.

Clinical problems such as depression are easier to describe and understand. For example, there is no need to accept a forced choice between depression as *either* a psychosocial problem *or* a brain disease. In the person game, all kinds of factors can be incorporated into a useful concept of depression that patients can identify with and respect. This can include both clinical depression, results of other physical processes such as heart disease, reaction to physical and personal losses such as loss of limb from diabetes, voice from cancer, or vocation from stroke. The significance of those symptoms is very easy to portray in the person game as contrasted with strict organism or mind views of depression which may not focus as much on interference with the person's participation in important social practices of the community. This allows for a more personalized and nuanced view that patients can understand and cooperate with.

End of life care readily blends physical, family, psychological, social and spiritual realities. These can be combined into one coherent plan and care team because control of suffering, connection to family and spirituality, and dying a good death become larger issues for goals of care than active treatment of disease. (Byock, 1997; Cassel, 1991). For example, the Medicare hospice benefit is a full-scale, complete and mainstreamed biopsychosocial approach to end of life care with a matching set of healthcare benefits which allows patients and families to deal with the full picture of death and dying with one coherent care team.

Patients are not asked to spend time and energy migrating back and forth between medical and behavioral professionals and clinics. This reduces the implicit expectation that patients learn to subdivide themselves into biomedical and mental health domains in order to get the attention they need. Person-centered design of the healthcare system helps patients preserve the person they are in the midst of their healthcare problems while mobilizing energy for coping with illness rather than coping with the system itself. This is described very clearly in Crossing the Quality Chasm, the Institute of Medicine's (2001) influential report that outlines patient centered, scientifically valid, and operationally excellent criteria for healthcare system design of the future.

Common Satisfactions For Health System Designers Or Researchers

Health systems designers are free to think innovatively and help renew everyone's confidence in the systems they work in. Mental health or biomedical disciplines that become too separated from the biopsychosocial realities of actual clinical presentations can generate the kinds of chronic dissatisfaction for clinicians outlined at the start of this paper. This is because the separation of physical and mental doesn't fit either what they confront daily in their patients or what they know themselves about being a person. Health systems suffer their own chronic dissatisfactions from being disconnected from reality in this way. As health system designers and managers redesign systems to treat health and illness more realistically, the relationship between caregivers and their organizations can improve. It becomes more satisfying for the clinician and improves the credibility of their disciplines to combine biomedical and psychosocial factors into one base of knowledge, clinical picture, field of action and "playbook" (Fischer, et al, 1997; Lucas & Peek, 1997). Health system designers and managers are key to making that a reality in actual healthcare organizations.

The main research question becomes "How is the person game best played?" This is different than "what's the evidence for playing the person game in the first place?" The game metaphor helps understand a common observation: Those who have found a way to do integrated care in daily practice often don't require further evidence-basis or proof that the idea is worthwhile. They find that the collaborative way of working significantly reduces their daily dissatisfactions with practice and makes good sense—with validity for patients and clinicians. That is, the decision to be person-centered is heavily a pre-empirical stance reflecting the kind of world and relationships people want to work in. But even when practitioners and patients are enthusiastic about collaborative care and the "person game" directly through participation in it, empirical evaluation is still needed—not so much to prove whether the game should be played, but to identify the fruitful and useless ways to play it.

A person might say "I don't need a study to find out if I like to play

this game better than the old games”. But this person still needs studies to show which of the systematic possibilities that come with integrated care pay off well and which make little difference. Integrated care and the person game have to be in place in order to study them. But systematic evaluation of which ways to play the game work well for patients and which do not is a continuing need. Another way to say this is that the pre-empirical task is to lay out the systematic possibilities for integrated medical and mental health care and the empirical task to discover which of these pay off.

The Spread of the Person Game in a Major League Healthcare Organization: A Story

Arguments for integrated medical and mental health care and the person game come to life better in an actual story of successful implementation. We tell this story using a three-stage developmental framework (from pilot to project to mainstream) illustrated with examples. The science, engineering, business, politics, and community metaphors are in full use in this story along with the game metaphor. Our story takes place in a large, multispecialty medical group associated with a health plan serving the Minneapolis-St. Paul area.

From Pilot to Project to Mainstream

Successful examples often develop over time from small-scale pilots or demonstrations between just a few clinicians to widespread and systematic application in the larger system or community. The goal is to spread benefit to more people in the community or population rather than remain an otherwise excellent but isolated pocket of collaborative practice. Table 3 shows three developmental stages, adapted from Davis (2001).

After better integrated medical and mental health care was substantially accomplished in this organization, Davis (2001) reviewed the history and described it as having moved through these developmental stages from pilot to project to mainstream. The authors also see this now as an evolution from pick-up games in the sand lot to better organized and

locally sponsored projects at medical clinics (local parks), to officially sanctioned strategies that created medical / mental health collaboration throughout the entire healthcare system (city league play).

Table 3. Stages of development for spreading integrated medical and behavioral care

	Stage 1	Stage 2	Stage 3
Davis (2001)	Pilot: A protected demonstration of feasibility & value	Project: Demonstrations led together as a visible, sponsored effort to create wider change	Mainstream: A full scale shift to a new way of life in the practice or community
The end in mind	Demonstration of improved care for a group of patients served by a small-scale collaborative dyad or team	Better care and service within the larger clinic or community; a better match between design of clinic services and patient needs	A care system that routinely delivers the right care at the right time in the right places by the right clinicians and teams—a complete design
Core group to engage	A few motivated clinicians who want to do things differently and note the results	Interested clinic/ community leaders including clinicians, managers, operations/financial staff	Care system / community leadership, across levels and areas
Common interests to build on	Clinician desire to better serve their panel of patients and to improve their working relationships	Clinic / community leader desire to better serve more of its population, learning from pilots and improving reach	Leadership investment in improving health, healthcare, service, and resource stewardship for an entire population of patients

First steps	Finding each other and working out a good-enough startup plan	Establishing clinic / community ownership and a viable clinic integration/ implementation team	Establishing care system ownership, executive vision and direction at the highest level
Operational or financial tasks	Local and pragmatic solutions, often non-standard or outside the usual system; maybe with seed money or time	Pragmatic solutions workable within the clinic system, with expectations of financial and time workability	Carefully crafted system-wide operational and financial designs to support a new clinical way of life throughout the care system / community
Game metaphor	Sand lot: A few people playing pick-up games wherever they can, with whomever they can, with whatever they can find around them	Local Parks: Locally recognized games on a few park fields, usually visible on the official park schedule	City league: A collection of teams across town, playing the same game as a normal part of the city program

Sand Lot or Pilot Stage (1980-92)

By the early 1980’s “pick-up games” appeared spontaneously between a therapist and doctor or two in medical clinics—mostly among a few physicians with past experience working with therapists and a few therapists who had already worked with physicians. All were restless with the current system of separate and parallel care. Pick-up games usually consisted of one or two doctors and a therapist or two improvising collaborative care of a few specific challenging or “difficult” patients or diagnostic groups, without a consistent or explicit general blueprint. These experiments were mostly not part of a formal system of care or operations, but

were pieced together with time, talent, and materials at hand.

This took place in a large medical system with geographically distributed clinics and a mostly centralized mental health department. Although there were many inspired and very thoughtful efforts from both sides to bridge care for specific cases, the dominant care delivery model in the mainstream remained the traditional separate and parallel system. Using the game metaphor, the organism game and the mind game were dominant. As expected, patients who needed better-integrated care were coming to medical clinics in much greater numbers than mental health clinics, regardless of their particular mix of biomedical and psychosocial problems. Because of this, medical clinics were where integrated care and the person game would mostly need to be played. A few key developments:

The first fully designed pilot. In 1984 the first deliberately designed and visible integrated care clinic was established within a dental clinic. The target population was chronic head, neck, and jaw pain and disability (temporomandibular disorder). Known as “the TMD clinic”, dentists, physical therapists and psychologists shared the same space, chart, systems, clinic management, and care plans. Moreover, the design included appropriate and harmonized clinical, operational, and financial aspects—one hallmark of a potentially enduring program. This proved quite successful for clinical reasons and because it squarely addressed the chronic dissatisfactions that patients, clinicians, and care system executives had with the care of this population of patients. This program became a template for other integrated care programs.

Beginning a systematic shift on the mental health side. By 1991, the second author arrived as the new Mental Health Department Head or “park supervisor” who said in effect “Let’s build some real fields. I’ve played this game before too. It’s a good game.” But the challenge was to attract others to play. Because the creation of a new game is essentially a social enterprise, he helped us bring together those who were playing the pickup games and worked with them to put the rules and equipment together as a more conscious effort to try something new in the system.

Everyone was invited to participate in integrated care. As expected, some people looked forward to playing in new ways and others did not. These differences sometimes led to what were seen as internal competition between professional models, professional elitism, or as critique of the usefulness or inadequacy of particular training. Sometimes this was experienced personally, and had to be redescribed as fundamentally a clash of paradigms rather than of persons.

New appreciation of the cultural shifts to a new “way of life”. A conceptual breakthrough occurred in 1991 when the first author heard the Presidential address at the annual meeting of the Society for Descriptive Psychology (Torres, 1991). This paper looked at cross-cultural adjustment and assimilation at the level of “a way of life”, not only at the level of specific behaviors. This made it clear to the authors that integrated care was a shift in clinician (and health system) “way of life” and that interventions at the level of specific behaviors would not be fully understood or appreciated without reference to this larger shift. We needed to recognize, appreciate, and create space for dialogue about showing up as a clinician in a new game with new rules, goals, and players. A related insight was that it is difficult to play the “person game” from within either of the old games. That is, the biopsychosocial paradigm and its practices cannot be fully contained within either the traditional biomedical or mental health paradigms alone. Like those in the sandlot, other clinicians would have to step out of their present “game” in order to appreciate and get good at the new one.

Local Parks or Project Stage (1992-1998)

Seeing the larger picture of professional identity, goals, relationships and “way of life” at stake here, the authors realized they needed to merge what they were learning about integrated care as a clinical approach with a companion organizational and professional approach. This was shaped in large part by the Descriptive Psychology concept of “an organization is a community with a mission” (Putman, 1990) in which organizational life and organizational change is cast as a form of community development rather than only solving business problems. The seeds of the game

metaphor were sown as the enterprise began to look more like a community development challenge than a technical problem to be solved. From this time on, all internal and external presentations and publications were a blend of clinical, organizational, and professional community issues surrounding the development of better-integrated care. This starter “rulebook” was needed if small pilot projects and pick-up games were to be rolled together into a larger, more visible cause. Some key developments:

Creating a large-scale shift on the medical side. In an accident of history, the organization recruited a new medical director for primary care who was a nationally-known family physician, also trained in family therapy. Already dedicated to integrated care and a seasoned player himself, he eagerly picked up the leadership on the medical side. This was important because leadership for the new game had been largely from mental health people. At this point, champions were working on both sides of the medical-mental health divide. The new medical director would engage the physicians as one of them while the authors continued to engage the mental health clinicians. This medical director went a long way to prepare all the primary care clinics (the local parks) for integrated behavioral health care. This included defining the scope of primary care to include behavioral health, including the authors in the primary care leadership team and adopting national quality targets and measures for depression, including the bulk of depression care (which takes place in primary care clinics).

An officially sponsored, visible project was created, in which four primary care clinics would expand and refine their capacity for on-site collaboration between physicians and mental health professionals. Integrated care rules of the game, a slate of measures, and a visible leadership team composed of people from both the medical and mental health side were pulled together. Using the metaphor, coordinated and publicized league play began in four local parks, while lots of the original pick-up games continued. Clinic-specific implementation teams were established to ensure successful operational follow-through in each site.

Creating a large-scale shift on the mental health side. With the visible championship and shifts taking place on the medical side, the Mental Health Department Head (second author) decided the time was right to mobilize a shift of mindset regarding the place of mental health in an integrated health system for his entire department of over 100 therapists and managers. He brought in an external consultant to facilitate a 3-day event that followed this general formula: Mobilize shared dissatisfactions with the status quo, create a shared vision of a preferred future, and take some first steps toward it. This process was described by Peek, Heinrich, & Putman (1997) and is outlined in generic form in Dannemiller & Jacobs (1992). This successfully shifted mindset at the level of “way of life” for mental health clinicians to more clearly include their place as part of a larger system of care, professional community, and interlocking relationships.

Shortly after this, project leaders secured a funded project to investigate the integrated care pilots or pick-up games through the research foundation. This marked a shift from a pre-empirical concern (here’s a new game—lets try it) to empirical concerns (How do clinicians and patients actually like this new game? What good does it do them? What plays work best?) Quantitative and qualitative results were positive and were published externally by Fischer et al (1997) and internally by Davis et al (1997). These findings pointed out clearly that the project was promising and a good candidate for mainstream application.

Appreciating the dangers of success. At about this time, the pilot-stage programs were becoming popular with physicians and patients. More referrals were made. But capacity began to be outstripped by demand. As mainstream demand was placed on pilot programs, they became backlogged and collected frustration and skepticism regarding their adequacy (Fisher et al, 1997). At this point, it became very clear that mainstreaming medical-mental health integration would require building in the right level of clinical, operational, and financial capacity at each stage. It was clear that success at one stage could set the stage for failure unless the programs were deliberately moved to the next stage. This was published as “from pilot to project to mainstream” by Davis (2001). The

danger of mainstream demand placed on pilot programs plus promising empirical results precipitated a move to go mainstream (city league play) rather than let things suffer at the pick-up or local park level as mainstream demand was building.

City League Play

As sand-lot and local park games began to suffer from lack of capacity in the larger system they were serving, it was clear that if this game was to survive it needed to spread and become league play. That would mean official sanction and sponsorship by top organizational leaders in the medical group, health plan, and associated clinical and administrative areas. A few key developments:

A merger precipitates a visible public examination. A second accident of history was a merger between the original medical group and another large one. During this process (some of which the first author facilitated) the question of the proper role of behavioral health in the care system was raised. Groups of primary care and specialty physicians came up with guiding principles for the place of mental health in the care system. This gave a boost to the new game because physician consensus for a more integrated model (the person game) across the organization was now explicit as a piece of the foundation of the new merged medical group.

The leadership group for integrated care and the person game came to include leaders from primary care, mental health, and research, along with executives from finance and clinic operations. This meant that a microcosm of the whole organization was now in charge of the project. By around 1999 it was clear that an integrated package of clinical, operational, and financial mechanisms would need to be established for integrated care— and that all of this would require examination at the top of the organization. So the authors, the primary care medical director and others prepared a presentation and detailed syllabus and went progressively up the chain of executive groups that included medical directors, COO, CFO, marketing, HR, and other functions. These groups saw promise in moving forward and gave the green light to continued systematic de-

velopment. It was still up to the clinics, departments, and administrative areas to make it happen on the ground of course!

Mainstream or National League

From 1994 onward, national attention was increasingly focused on medical – mental health integration. National conferences were held and books were written. A flood of books and articles on this topic appeared between 1997 and 2002, often citing promising developments in care systems including the authors' own. The books and conferences also showed that the person game was not just about integrating biomedical and mental health care. It is an important feature in all healthcare, e.g., for chronic care, rehabilitation, and end-of-life care. Key developments:

Connecting local progress to national trends. The authors routinely linked the locally developed new game to national trends that support better integration of biomedical and psychosocial care. These included federal agencies such as the Bureau of Primary Healthcare and Veterans Affairs, credentialing organizations such as the National Council for Quality Assurance (NCQA), foundation grants and think tanks such as the Institute of Medicine, Institute for Healthcare Improvement, and Robert Wood Johnson Foundation, the Collaborative Family Healthcare Association, the remarkable development of counseling in primary care in the UK, and the efforts of other large organized care systems in the U.S. The authors and others began pointing out within their organization that there is a national arena forming in which large organizations are becoming players. This helped give additional significance and impetus to developing local teams and play across the organization. Integrated care appeared to be an idea whose time has come— a game that is ready to become a national pastime.

A next generation of leaders. By 2002, the authors had turned over responsibility for integrated care in their own organization to managers and leaders in behavioral health and primary care. It was those leaders' turn to have fun with it, play and coach it themselves, acquire deeper “player's knowledge” of the game and build the relationships across the organization that come with playing the person game. In addition, be-

behavioral health integration became an increasingly normal part of organizational initiatives such as chronic illness care and a bold response to the challenges of the 2001 Institute of Medicine report, “Crossing the Quality Chasm” which straightforwardly holds out a biopsychosocial approach that includes both evidence-based and patient-centered care.

As the authors and other founders released the project to take their quest to different settings, a critical test is how the game is going without them around. A 2004 scan speaks for itself. About two-thirds of the 20+ primary care clinics in the system had on-site mental health professionals doing integrated care with physicians. Approximately 21 adult and child therapists and psychiatric nurse specialists were in at least one medical clinic, adding up to about 10 FTEs serving both adult medicine and pediatrics. One FTE of behavioral health time was devoted to oncology for psychosocial care of cancer patients and part of another is devoted to the dental division for care of chronic temporomandibular disorder (neck, head, and jaw pain—the first integrated program that began in 1984). A geriatric psychiatry presence split 1 FTE between 3 psychiatrists, 1 nurse practitioner, and three psychiatric nurse specialists who are fully integrated into the Geriatric Division. The “person game”, and broadly, “person medicine” continues to be played and spread in this organization and across the country. Name recognition for integrated care or collaborative care (this new game) was higher than before, and more players were finding more and better equipped playing fields than ever.

Lessons learned: What We Would Do Differently, Using the Game Metaphor From the Beginning

Many events—planned and unplanned—comprise this 15-year story. Looking back with 20 / 20 hindsight, we have identified things we would now do differently had we been thinking in terms of creating a new game in town in addition to cracking clinical, scientific, engineering, systems, business, and political problems. Many of these seem obvious in retrospect, perhaps especially to those readers whose initial reaction was to think that the whole problem and solution is painfully obvious in the first place. But from within, things were not so obvious.

Use the game metaphor in ordinary conversation to attract all potential players

We would have used the game metaphor in ordinary conversation to clarify the nature of the challenge and make an open invitation to play. Using the game metaphor changes strategy for spreading the integrated care innovation—by opening it to everyone and emphasizing opportunities to try it out. At the outset, the mission for the first group (around 1990) of mental health clinicians championing integrated care read this way:

To create within the organization an innovation in the provision of health care services. This innovation shall be marked by:

- A biopsychosocial model of human health and illness
- Paradigm shifting methods for synergizing the work of medical and mental health professionals
- The actual integration of medical and mental health care at clinics with health psychologists
- The appearance of seamless systems of care for complex patients for whom separate and parallel medical and mental health care leads to unsatisfactory clinical, operational, or financial outcomes

This mission served quite well at the beginning for this particular small group but in retrospect a more inclusive, accessible, and inviting mission for the whole project (rather than just this group) would have been very helpful. The mission statement used then had several flaws when viewed through the lens of “bringing a new game to town”:

1. It applied to a small and particular group rather than being an open-ended invitation to a broad community of potential players. “Players” appeared limited to mental health and medical clinicians rather than anyone who could use a new, more “person-centered” game in their own world— including managers, operations, finance people, and those in chronic illness and end-of-life care. It further limited mental health players to health psychologists, the founding group.

2. The first two markers of success were academic statements featuring models rather a practical statement featuring the creation of a better and “more fun” way to deliver and receive care for everyone.

3. The final marker, though precise and still applicable, presupposed awareness of the problems the “new game” was intended to solve, and hence had face value to only a subset of potential players who *already* knew why someone would want to play a different game.

4. This mission did not feature building connections to the many people all across the country working for the same thing in their own worlds in their own ways. (from local parks to national league)

5. This mission included no reference to moving along a developmental sequence for spreading the innovation such as the “pilot-project-mainstream” stages or the earlier “idea-invention-innovation” schema (Peek & Heinrich, 1995).

To be fair to ourselves, we probably needed to walk our path to realize these things. But if we had grasped the value of adding the game metaphor to the mix (and the real challenge before us) we would have written mission and goal statements differently. We would no doubt have included clarifying references to the metaphor such as “bring a new game to town”, “create a national pastime”, “evolve from pickup games in the sandlot to national league play”. These are humorous thumbnail expressions of the *significance* of developing integrated care. In Descriptive Psychology, the significance of some action is “what you are doing by doing that”. At some point when you keep asking “what are you doing by doing that?” you arrive at a statement that needs no further explanation, such as “bring a new game to town and live to see it played as a national pastime”. This probably gives a more realistic impression of what the multifaceted task is than restricting the significance to scientific, technical, or business tasks.

Routinely engage people as “players” rather than as spectators. Clearly the founding groups of mental health and medical clinicians were “players” – that is how they became enthusiastic about the new game. But

that lesson was sometimes lost. Attempts to recruit new players, especially managers, finance, operations, and executives were done through persuasion, appealing to the data, testimonials, and appealing to enlightened self-interest of various kinds.

What we did not automatically do (but would now) is find a way to engage these people in the game itself. We would now devise some form of participation suited to the person's role (whatever it is) where they could experiment, see results, try things themselves. People would feel like they are on the team—the actual roster-- not merely a shareholder or sponsor facing yet another group of good people asking for their name or money. Failure to do this with organizational leaders probably made widespread acceptance slower and less enthusiastic (though it did happen anyway). Interestingly, high-level leaders who were obviously and visibly on the team were usually those who at one time or another played pickup games themselves—mostly physicians or other clinicians who had discovered early in their careers the joy of this kind of play.

The lesson is that no one becomes a player through exhortation, appeal to data, or argument. People become players (and maybe enthusiasts) when they have a chance to try the game on their own terms. Creating a project structure and diffusion strategy that featured giving everyone a chance to play the game would have been very different from what we did—appealing to those who weren't already in the game through traditional rational approaches with argument, data, publications, and enlightened self interest.

In Descriptive Psychology, this is referred to as “engaging the actor” rather than the observer or critic function (Putman, 1998, p.131-133). There is much more fun in being in the actor role—when people get to “be themselves”—than in being merely an observer, critic or support person on the side. People come to enjoy playing baseball or any other game or activity by *playing* it, by *being* baseball players—and getting the hang of it (Ossorio, 2005)

The following five maxims for “becoming” offered by Putman (1998, pp. 143-150) would now serve the authors as reminders while trying to

help persons become integrated care players.

1. A person becomes what he acts as. In addition, involvement precedes appreciation.

2. A person acts as who he takes himself to be.

3. A person takes himself to be what he is treated as being.

4. A person becomes what he is treated as being.

5. A person becomes what the situation calls for him to be.

While not guaranteeing results, these maxims would have been helpful to keep in mind while trying to recruit new players and shift professional practices and identity in a new direction.

Point out opportunities for taking game-type satisfaction while playing the person game. People seek out and learn even difficult games because of the challenge and satisfaction they bring, even when there is no extrinsic or instrumental reason to devote all the effort. The person game, like many real games, creates valuable opportunities to develop oneself and have fun. In retrospect, we would have tapped into intrinsic motivation that games often provide to:

- Develop sensitivity and judgement within the domain of the game—in this case, sensibilities which are not only practical on the job but useful in everyday life.
- Recognize, study, and appreciate strategies used by others in this larger domain that contains more elements. Then create strategies of your own and have them appreciated by others. The ceiling for strategy development is raised, much like when moving from playing checkers to playing chess, even though the board is the same.
- Exercise skills—intellectual, relationship, design, and conceptual as well as procedural. People enjoy “making the right moves at the right time”.
- Achieve intrinsic satisfaction and mastery in the interactions and

partnerships called for by the game. People enjoy team play when done well and often go out of their way to choose team-based activities rather than solo modes of play.

- Achieve a certain status within the professional community, e.g., being at a certain level of play or respect or having certain “statistics”. People appreciate and accredit others who obviously “know the moves” or “have a black belt” in integrated care.

Some of these satisfactions might well appear on a list of what people often call “the joy of medicine” to be recaptured in daily practice.

Be explicit about the process of spreading the game. Spreading from pickup games in the sandlot to local parks and city league to national league turned out to be a necessary and systematic process. We would now use this image to show people that settling for pickup games and local play, while good, does not make the desired imprint on the larger scheme of things. Eventual success has to do with spreading the game, not just inventing it, and there is a systematic way of thinking about and doing that. The concepts of developmental sequence did occur to us (from Idea to invention to innovation, Peek & Heinrich, 1995) and later came to us in a better way (from pilot to project to mainstream, Davis, 2001). But these sequences were anchored in industrial and organizational development metaphors. We think adding in the game metaphor would have made this more intuitive and less academic sounding. Who wouldn’t want to move their favorite game from the sand lot to city play to the national league?

Use the empirical findings of the “diffusion” literature. Using the literature on diffusion of innovation (Rogers, 1983) would have helped us design the details of the games so that people would truly want to play—and bring their friends. We suggested earlier that the choice to play the person game (do person-centered care) is not completely empirical. It is more of a statement of values, how you want to deliver and receive care, and what kind of world you want to live in. But at the same time, some games are more attractive and spread faster than others. Some of the possibilities inherent in person-centered medicine are much more practi-

cal or appealing than others. The diffusion literature could have helped us with that earlier than it did.

For example, Rogers (1983) says that adoption of an innovation in any given population follows a pattern. An innovation starts with an innovator, often one person with a new idea (if there really is such a thing as a new idea). The innovation spreads slowly at first, usually through the work of pioneers or change agents who actively promote it—then picks up steam as more and more people adopt it. Somewhere along the line it reaches a take-off point when the number of early adopters reaches a critical mass—between 5% and 15%. At that point the innovation gets a life of its own, as more and more people talk about or demonstrate the innovation with each other.

The task is to get things up to the take-off point, which we think we did. However, we could have been smarter about just what that takes—and done it more quickly. For example, the innovation literature identifies five characteristics that go with successfully spread innovations (Rogers, 1983).

1. *Relative advantage*. Is the innovation distinctly better than usual practice? Will people perceive it as better? If not, the innovation will not spread quickly, if at all.

2. *Compatibility*. How does the innovation fit with past experiences, present needs, and existing values? If it doesn't, it won't spread well. If people feel like they have to become very different people to adopt the innovation, they will resist it. "I can't play this new game and still be me!"

3. *Complexity*. How difficult is the innovation to understand and operationalize? The more difficult, the slower the adoption process. "This is just a way to make life harder."

4. *"Trialability"*. Can people "try out" the innovation first? Try out the game before buying it? Or must they commit to it all at once? If the latter, people will be quite cautious about adopting it. "Can't I return this if I don't like it?"

5. *Observability*. How visible are the results? Is there a score? Can you produce “stats?” Can the scores and stats be observed and understood by others? If not, the innovation will spread more slowly.

How we would have done things differently using the diffusion literature. Had we carried index cards with the characteristics of successfully spread innovations written in big letters from the very beginning, we would have done several things differently.

First of all, we would have designed the interventions for areas likely to produce more spectacular results for clinicians and the care system. The very first systematic pilot (the “TMJ clinic”) did just that, but subsequent work mostly had more subtle though valuable targets.

We would also have taken pains to ease any “culture shocks” and “identity crises” in taking up the new game. As it was, we depended largely on testimonials, word of mouth, professional arguments, and trends in the literature. Those who were convinced, especially within the mental health area, became a culturally more distant subcommunity rather than becoming more connected to the mainstream until quite recently in 2002. We would have created brief “internships” or “visiting clinician” programs that allowed people to actually try the new game with support and supervision from experienced players. We could have built in the opportunity for clinicians (both medical and mental health) to “shadow” their peers in this new practice, debrief, and even begin to interview and treat patients themselves within this program— all with no obligation whatever. This “money back guarantee” would have been extremely helpful for clinician managers, not only front-line clinicians.

To make things easier to understand, we would also have kept integrated care programs simpler and more standardized where we could. In our efforts to tailor things to local clinics, we sometimes allowed complexity or fuzziness to creep in. If we had been more conscious of the eventual need for “league play” and a simple rulebook we might have made the innovation spread more easily—as long as we didn’t go so far that we were accused of promoting a “cookie cutter” approach. This would also have made it easier to create and use a systematic “scorecard” from the

beginning with a slate of measures for each aspect of the program's mission— the classic “balanced scorecard” approach that taps clinical, operational, financial, and satisfaction areas. We could have posted these “stats” regularly and let people talk about them and even “compete”. We did in fact do quantitative and qualitative analyses from time to time and even published them. However, this is no substitute for a posted scorecard with “stats” meaningful to individuals and teams.

We would also have borrowed from the mature literature on the anthropology and spread of games. We didn't even touch that, but would no doubt look into it were we to take on a project like this again. Finally, there are insights from unexpected sources that accidentally pop into view. Here is an example of what attracts a person to a new game, taken from a 2004 Google search on “diffusion of games”, posted to a video game blog by “jay”:

“What gets me most excited about a game is not whether I have had any prior experience with it, such as with a sequel in a series or franchise; or whether it contains any recognizable characters or locales as with a license. For me, it's the possibility of going to a new world undiscovered, or experiencing gameplay mechanics unfamiliar yet comfortable and natural to the touch. It's a game which defines a new genre, or defies existing ones; a game so gratifying to play, it demands playing over and over again”.

What an informative snapshot—insights we could have used from the beginning in our own project. Images such as “going to a new world undiscovered” or “experiencing gameplay that is unfamiliar yet natural” would have been helpful as we designed our new integrated care programs and introduced them to clinicians. Today, we would set up our own “blog” on which person medicine players could post their own observations and insights on what makes it work well or not for themselves and for patients.

Raise more outside funds to help finance early experiments. At the beginning it is difficult to secure funding for experiments and new games

from local grassroots operations. People generally want to see a playable game before they buy anything. This is particularly true in healthcare delivery organizations whose margins from providing care are very slim if not negative. Local clinics are tightly budgeted to cover clinical expenses, not experimentation with “paradigm-shifting methods for synergizing the work of medical and mental health professionals” as the mission statement read at the beginning.

Rather than expecting clinics to just contribute time and materials while sacrificing production to these demonstrations, we would now find ways to provide in-kind support, e.g., from small external or internal grants or some form of “bake sale” that could provide just enough financial support to make it easier for clinics to spend time and energy trying new things. Our project was not usually budgeted beyond our own time and corporate technical support. Only once did we secure a significant external grant to finance things—and that was for a formal published research project (Fischer et al, 1997).

Connect with the larger patterns in person medicine sooner. Integration of biomedical and psychosocial healthcare is only one aspect of person medicine or the person game. But at first we treated it as the only instance of person medicine—which it wasn’t, especially later on. The following major thrusts or pressure points in healthcare all involve what we call person medicine and invite a place within them to play the person game.

Chronic care and disease management protocols and systems. Care of chronic conditions such as diabetes, heart disease, asthma and depression is a major challenge, especially in our aging population. The Chronic Care Model (Wagner, et al 1996) is designed for proactive care of all chronic illness and is clearly a person-centered approach, emphasizing a common biopsychosocial approach across all specific diseases. This model also builds in evidence-based medicine and patient centered care as described earlier.

End of life care and palliative care. End of life care and the hospice movement is a field which is early adopter of person medicine and in-

cludes some of the most mature philosophy, clinical methods, operational systems, and financial benefits systems in existence. For example, an entire package for person medicine is contained in the Medicare hospice benefit and requirements for providers.

The Institute of Medicine report, Crossing the Quality Chasm: Healthcare for the 21st Century. This widely read and influential 2001 report declared in no uncertain terms that the system is broken and proposed a set of new rules for healthcare and contrasted them with the old rules. A major theme is the continuing need to better integrate the overall system of healthcare, including integration of patient-centered and evidence-based care. For example, inadequate teamwork and coordination between primary care and specialty physicians across all the “handoffs” and transitions often leads to fragmented care, especially when mental health aspects are present. The “person game” comes with a large repertoire of care management and continuity-preserving methods for keeping complex cases from “coming off the rails” during times of rapid change and involvement of many providers both in chronic and acute situations. This is a universal healthcare system challenge (and problem) which goes far beyond medical-mental health integration.

Unfolding legislative and policy dramas. Some policy issues that came up along the way involved benefits for complex conditions, payment methodologies, clinician training, and other “rules of the game” as determined by State and federal governments. On one occasion in the late 1980’s a hearing at the Minnesota State legislature set the terms for insurance coverage and appropriate clinical integration for chronic craniofacial pain (TMJ syndrome) as part of the regulation of HMO’s. Our very own 1984 vintage program was cited as one of two in the State that provided the right mix of clinical care, operational procedures and covered benefits. But beyond that, we did little study or participation in policy debates or “white papers” for policy use. We would do more of that today.

We did engage these trends in our presentations and writings, but did not effectively make the policy connection for many of the local play-

ers. To see and feel that you are part of making a seismic change in your field through your own efforts to create and spread a new game in town would, we think, have helped the innovation spread faster. Moreover, our many presentations, articles, book chapters, and book were aimed at professional audiences— not consumer or policy audiences. Now we would write for all these audiences—including all of them together (Pronk, Peek, & Goldstein, 2004). Everyone has a stake in this game— not just the professional audiences.

Conclusion

Better integrated medical and mental health care is part of the future, along with other aspects of person medicine and the person game. This paper was written to explore why this obvious clinical innovation has been so difficult to spread, and how it can help to view spread as creating a new game and turning it into a national pastime. We have featured this metaphor in context of other metaphors in healthcare, told our story, and listed the many ways we would have done things differently had we added this metaphor to the mix all along. We conclude that change projects such as this can benefit greatly from viewing them through several lenses at once.

- Clinical, organizational, scientific, or business problems to be solved
- Professional, political, or organizational community practices to be improved
- A new game to be created and turned into a national pastime

All these lenses are important, and none is sufficient all by itself. Each carries an overlapping but somewhat different set of observations and lessons about change and attracting people to positive change. Each has different images and locutions that speak to people situations more clearly at different times. Our own work depended heavily on the first two, and suffered to some extent by the absence of the third.

We conclude that recasting our work as creating the person game as a national pastime was not just a flash of insight about the enormity of what we were really facing and why we felt as we did. It has enduring value in the design of programs and change processes—including those resting on evidence and the business case. There is always a human case to be made as well. One way to build and test the human case is to think of the change as a new game and then see if you can attract anyone but a few enthusiasts to play it.

As we said before, the decision whether or not to *play* a particular game rests on more than empirical data. It depends also on what kind of life and world a person wants to live and work in— and the values and relationships that are to govern that world. The decisions on just *how to play* the game— which possibilities inherent in the game actually pay off and which don't— is an empirical matter. We believe that a unified evidence base, business case, and human case is facilitated by comparing change to the spread of games— something that everyone has experienced.

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