

Virtual Mentor

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Resistance to Changing Roles in the Medical Team

Commentary by Erin L. Bakanas, MD

Dr. Cowell, a physician leader and the CEO of Saint Elizabeth Health Network, has scheduled a meeting with the network physicians. Due to recent budget cuts and growing expenditures, Dr. Cowell must institute some changes at Saint Elizabeth. She informs the physicians that, although the quality of their care is not being questioned, expenses are rising, and she plans to encourage certified nurse practitioners to participate in team leadership.

In the currently accepted team dynamic at Saint Elizabeth, physicians head all care teams. Nurses, physician assistants, and all other practitioners report to a physician team leader. Now, Dr. Cowell explains that this model will be phased out. Certified nurse practitioners will be offered leadership courses and move into positions of increased clinical leadership so that they can head new teams.

In this particular state, nurse practitioners are legally allowed to practice autonomously. They can act as primary care clinicians, prescribe most drugs, and order physical therapy, and they can sign death certificates, handicap parking permits, and workers' compensation claims. As a part of their new role at the Saint Elizabeth, nurses will coordinate care, order consults, and make referrals for specialty care.

Dr. Roth, the president of the local medical association, responds by accusing Dr. Cowell of turning her back on her fellow physicians and violating the oath she took when she entered the field of medicine to best serve their patients. Dr. Roth says that Dr. Cowell might be acting like a corporate business leader but certainly is not acting like a physician leader.

Dr. Roth insists that nurse practitioners are not a safe or effective replacement for physicians. He says, "This is certainly not going to save us any time; nurses do not know enough or have enough experience to be able to refer properly or carry out consults. Physicians will not respond to calls for consults from nurses in the same way that they respond to calls from physicians. If the unnecessary referrals are made, we will be wasting the time and money of the receiving physician, the patient, and the hospital. We can't risk our patients' lives—one missed referral or misleading consult could mean delaying necessary and life-saving treatments."

Commentary

The U.S. spends more per capita on health care than any other nation. Despite this, our health outcomes rank poorly in international comparisons [1]. Nor does our system provide the safest care—in 2001 the Institute of Medicine (IOM) report *Crossing the Quality Chasm* estimated that up to 100,000 patient deaths occur annually in U.S. hospitals due to shortcomings in care. Millions of Americans are uninsured and lack access to affordable care [2]. We have a shortage of primary care physicians, and expect that to worsen with the influx of newly insured patients as a result of the provisions of the Affordable Care Act. By 2020, the Association of American Medical Colleges projects, there will be a shortage of about 45,000 primary care physicians [3].

The system is unsustainable as it stands. Moreover, one could easily argue that failure to move on system reform is unethical—we cannot continue to endorse a system in which patients receive substandard care or, at the extreme, no care at all.

Data show that restructuring health care delivery can result in improvement in both access to care and health outcomes while reducing expenditures. For example, at least one study suggests that access to high quality primary care leads to less hospital use, less expenditure, and better health outcomes [4]. Ashton et al. reported in the *New England Journal of Medicine* in 2003 on the effects of restructuring the Department of Veterans Affairs (VA) system in the 1990s, particularly the closing of several hospital beds and the institution of regional integrated service-delivery networks [4]. Following cohorts of patients with nine different chronic medical conditions over a 5-year period, the authors noted a decrease in hospital and urgent care use and a small increase in primary care visits. The patients had similar or better survival rates than similar patients before the restructuring.

In a commentary on that study, Fisher said that states with high per-capita spending provided a lower quality of care [5]. In regions with more conservative practice patterns, Medicare patients have more access to care, better satisfaction with care, and, for certain diagnoses such as hip fracture and myocardial infarction, better survival. Fisher's interpretation that high-intensity practice patterns are not only wasteful, but might also be harmful, cannot be proved but should not be rejected. He argues that the results achieved by the VA's restructuring are worth noting and identifies three main areas to consider. First, the current system has misaligned incentives that encourage overuse of services—hospitals and doctors get paid more if they do more. Second, patients need better information and education about what medications and medical procedures have to offer that is truly beneficial to them, and not just promoted by businesses that seek to profit from medical consumption. And finally, the effects of local health care supply may drive a system either to overuse or to better quality and efficiency of care, depending on how that supply is structured.

Is Dr. Cowell’s Proposal Safe?

If health care expenses need to be controlled, and better primary care availability seems to both improve patient outcomes and lower costs, are nurse practitioners a safe and capable option as independent primary care clinicians?

Multiple studies have examined this question. For example, Mundinger et al. designed a study to compare the quality of primary care provided by nurse practitioners with that delivered by physicians [6]. Close to 2,000 patients were randomly assigned to either a nurse practitioner or a physician for primary care at five different clinics that were all affiliated with the same urban academic medical center. Outcomes measured included patient satisfaction after the first visit and, at 6 months, patient satisfaction, self-reported health status, physiologic measures including blood pressure, peak flow, and glycosylated hemoglobin, and health service utilization. The study found that all participants reported improvement in health status from baseline to follow-up. There were no statistically significant differences in the two groups for any of the parameters assessed—satisfaction, self-reported health status, physiologic measures, or utilization. In a follow-up study, Lenz et al. did a repeat analysis of patients after 2 years [7]. Again, there were no statistically significant differences in the outcome parameters assessed. The authors concluded that the study hypothesis was proved: “in an ambulatory primary care environment in which nurse practitioners have the same authority, responsibilities, productivity requirements, and patient population as physicians, the outcomes (health status, satisfaction with care, utilization of health services, and selected disease-specific clinical indicators) will not differ for the two provider groups” [8].

Does Professional Guidance Support Such a Proposal?

In the 2010 report *The Future of Nursing: Leading Change, Advancing Health*, the Institute of Medicine recommended reform of state scope-of-practice laws to allow nurse practitioners to fully exercise their skills [9]. The report also recommended that Medicare law be changed to allow nurse practitioners to be reimbursed at the same level as physicians for the same services. In addition, it recommended that the Federal Trade Commission evaluate and encourage change to state regulations that have an anti-competitive effect without adding to patient care safety or quality.

Pohl et al. have argued that the current restrictive regulation of nurse practitioners is expensive and inefficient and does not add value to health care [10]. They argue that a less restrictive environment would further access, efficiency, quality, and attention to cost. Teamwork and collaboration have been identified as competencies for practice by a number of professional organizations including the Accreditation Council for Graduate Medical Education (ACGME), the American Association of Colleges of Nursing, and the National Organization of Nurse Practitioner Faculties [11]. A central issue is a clearer understanding of what collaboration should look like. If it is limited to mean supervision by doctors, then nurse practitioners are not empowered to use their full abilities in patient care. A more effective model of collaboration emphasizes teamwork and, central to this, communication. What does true teamwork require? Gardner posits that it demands the development of trust and

respect as well as power sharing [12]. Pohl notes that many physicians and nurse practitioners believe it is better teamwork and collaboration that distinguishes the higher quality primary care practices rather than the particular professional credentials of the leader of the practice [10].

Achieving Organizational Change

It is clear from our scenario that a transition to more primary care services being provided by nurse practitioners functioning independently is going to meet with physician resistance, despite support from multiple professional organizations like those I have mentioned. But Dr. Roth's commitment to the goals of medicine can be an asset to Saint Elizabeth. Physicians should be encouraged to take an active and positive role in system reform. Ara Darzi, who devised a plan to guide the National Health Service of the United Kingdom through a reform that focused on improving high-quality, accessible care, urges clinicians to be the guiding voices in the conversation about how best to serve patients, cautioning that giving bureaucrats and insurance companies too much control steers the focus away from patients and toward profits [13]. Gunderman and Kanter, too, argue that active physician involvement in leadership of health systems [14] is part of the Hippocratic duty to put patient interests first. Physicians' moral commitment to patient welfare can make sure health care institutions balance ethics and economics.

So how can physicians be actively involved in changing their institutions' cultures? Dr. Cowell could employ a process like Peter Pronovost's that encourages thoughtful, active involvement in culture change on the part of staff. Pronovost, a leader in instituting checklists in clinical care to improve patient safety and quality [15, 16], recommends four guiding questions for executive leaders, team leaders, and frontline staff working on culture change in the hospital: engage (how do I make the world a better place?), educate (what do I need to do?), execute (how do we ensure we do it?), and evaluate (how will I know I made a difference?) [17].

But physicians working in interdisciplinary teams must not only lead but also collaborate. The Saint Elizabeth staff could be helped to adapt to changing roles by teamwork training. The Agency for Healthcare Research and Quality (AHRQ), for example, has developed TeamSTEPPS, "an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and teamwork skills among health care professionals" [18]. Dr. Cowell could also adapt some strategies from interdisciplinary training programs in health professions schools. For example, at Saint Louis University School Medical Center, students of medicine, nursing, physical therapy, occupational therapy, dietetics, social work, and pharmacy meet regularly in a year-long series of seminars to discuss patient cases in terms of patient-centered care, patient safety, health care systems, cultural competency, health literacy, and community resources. Such gatherings could help Saint Elizabeth staff learn new ways of working together and seeing each other. As a proponent of the interprofessional programs noted, I believe such training is necessary for health care professionals to learn to "respect each other's areas of expertise and contributions to their shared mission" [19].

Conclusion

Dr. Roth should be commended for his concern about patient care quality and safety, but his assertion that nurse practitioners cannot provide safe or quality care is unfounded. He should be encouraged to advocate for the best patient care and participate in team-building exercises that will gain him familiarity with the abilities of nurse practitioners. Contrary to his concerns about Dr. Cowell, this CEO has responded to the ethical necessity of controlling the network's expenses while keeping quality patient care the central focus [20].

References

1. Organisation for Economic Co-operation. OECD health data 2012: how does the United States compare? <http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf>. Accessed May 8, 2013.
2. Centers for Disease Control and Prevention. Health insurance coverage: early release of estimates from the National Health Interview Survey, January-September 2012. <http://www.cdc.gov/nchs/data/nhis/earlyrelease/Insur201303.pdf>. Accessed May 8, 2013.
3. Association of American Medical Colleges. The impact of health care reform on the future supply and demand for physicians; updated projections through 2025. https://www.aamc.org/download/158076/data/updated_projections_through_2025.pdf. Accessed May 8, 2013.
4. Ashton CM, Soucek J, Petersen NJ, et al. Hospital use and survival among Veterans Affairs beneficiaries. *N Engl J Med*. 2003;349(17):1637-1646.
5. Fisher ES. Medical care--is more always better? *N Engl J Med*. 2003;349(17):1665-1667.
6. Mundinger MO, Kane RL, Lenz ER, et al. Primary care outcomes in patients treated by nurse practitioners or physicians: a randomized trial. *JAMA*. 2000;283(1):59-68.
7. Lenz ER, Mundinger MO, Kane RL, Hopkins SC, Lin SX. Primary care outcomes in patients treated by nurse practitioners or physicians: two-year follow-up. *Med Care Res Rev*. 2004;61(3):332-351.
8. Mundinger, 59.
9. Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. http://www.thefutureofnursing.org?IOM_Report. Accessed May 8, 2013.
10. Pohl JM, Hanson C, Newland JA, Cronenwett L. Unleashing nurse practitioners' potential to delivery primary care and lead teams. *Health Aff (Millwood)*. 2010;29(5):900-905.
11. Riebschlienger M, Bohl J. Chapter 8: New standards for teamwork: discussion and justification. *ACGME 2011 Duty Hour Standards*. Accreditation Council for Graduate Medical Education. <http://www.acgme-2010standards.org/pdf/monographs/jgme-11-00-53-56.pdf>. Accessed May 8, 2013.
12. Gardener DB. Ten lessons in collaboration. *Online J Issues Nurs*. 2005;10(1): manuscript 1.
13. Darzi A. A time for revolutions—the role of clinicians in health care reform. *N Engl J Med*. 2009;361(6):e8.

14. Gunderman R, Kanter SL. Educating physicians to lead hospitals. *Acad Med*. 2009;84(10):1348-1351.
15. Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *N Engl J Med*. 2006;355(26):2725-2732.
16. Gawande A. The checklist. *New Yorker*. December 10, 2007. http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande. Accessed May 8, 2013.
17. Pronovost P, Berenholtz SM, Goeschel CA, et al. Creating high reliability in health care organizations. *Health Serv Res*. 2006;41(4 Pt 2):1599-1617.
18. Agency for Healthcare Research and Quality. TeamSTEPPS: national implementation. <http://teamstepps.ahrq.gov/>. Accessed May 8, 2013.
19. Brown T. Healing the hospital hierarchy. *New York Times: Opinionator*. <http://opinionator.blogs.nytimes.com/2013/03/16/healing-the-hospital-hierarchy/>. Accessed May 8, 2013.
20. American Medical Association. Opinion 8.02 - Ethical guidelines for physicians in administrative or other non-clinical roles. <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion802.page>. Accessed May 8, 2013.

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