

*Virtual Mentor*  
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Physician Leadership and Team-Based Care

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# Virtual Mentor

American Medical Association Journal of Ethics  
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## FROM THE EDITOR

### Redefining Leadership and Medical Teams

The increasingly specialized nature of medical knowledge and clinical technology has created the need for teams rather than individuals to deliver comprehensive care. Furthermore, the Affordable Care Act of 2012, with its emphasis on coordination among medical specialties to provide continuity of patient care, reinforced the urgency of team development. In response, formation of care teams has sometimes outpaced the readiness of team participants, resulting in clinical and ethical concerns. The June issue of *Virtual Mentor* takes a look at the ethical impact of team-based care in three arenas: clinical practice, medical education, and administrative leadership.

In clinical practice, responsibility for patient care is shifting from individual physicians to groups comprising different specialists who, together, are accountable for “episodes” of care. This shift necessitates a change in the traditional fee-for-service pay structure, in which individual physicians billed and were paid for each separate treatment intervention.

William Bond, MD, MS, discusses the incentives that will govern clinical care in pay-for-performance structures like accountable care organizations.

The “team” challenge, so to speak, is that doctors, nurses, pharmacists, and others, e.g., physical therapists, working as a clinical team must provide integrated, coordinated patient-centered care, despite the specific competencies that each possesses and spheres of practice that each represents. Robert Walker, MD, examines the dynamics of team member relationships and explains how teams should respond when one member’s behavior is at odds with the team’s shared goals and standards.

The role of the medical team leader, too, will need to be defined and understood in order to guarantee the best and safest care for patients. Catherine M. Lynch, MD, explores the stereotype description of women’s leadership style as more “collaborative” than men’s and asks whether that notion implies that women would “naturally” make better medical team leaders. Valarie Blake, JD, MA, reviews new Virginia legislation that expands the role of nurse practitioners, placing physicians in an increasingly supervisory role but with all the burdens of malpractice liability still on their shoulders.

Connecting the concepts of leadership and team-based care, Ashley M. Hughes and Eduardo Salas, PhD, discuss leadership and hierarchical structures as they apply to clinical practice. John H. Armstrong, MD, adds to that conversation by describing

various leadership styles, concluding that some promote while others undermine team cohesion. Daniella M. Schocken, Aliye Runyan, MD, Jason Wilson, MD, and Anna Willieme, MFA, consider hierarchy in medicine through artists' eyes, tracking trends in medical practice through famous paintings that depict medical professionals in their traditional garb.

The transition to team-based practice must also shape medical training. A truly interprofessional education team—Dawn M. Schocken, MPH, Amy H. Schwartz, PharmD, BCPS, and Frazier T. Stevenson, MD—provide insight on interprofessional education activities that address hierarchy and role fluidity. Alicia D.H. Monroe, MD, and Allesia English, MD, PharmD, discuss the SELECT (Scholarly Excellence, Leadership Experiences, Collaborative Training.) program, a new collaboration between the University of South Florida Health Morsani College of Medicine and the Lehigh Valley Health Network that focuses on fostering emotional intelligence in students to make them skilled collaborators and, eventually, executive leaders.

When physicians assume positions of responsibility, whether as leaders of a medical practice, accountable care organization, or hospital, particular ethical concerns must be recognized and resolved. Erin Bakanas, MD, MA, comments on the responsibilities of physician executives who adopt interprofessional models of care that meet with physician resistance. How can these practitioners balance their responsibilities to the field of medicine with their duties as members of an executive leadership team, roles with separate goals that may not align? Primi Ranola discusses “Physicians versus Hospitals as Leaders of Accountable Care Organizations,” an article probing the possibilities of future organizational structures controlled by physicians and by hospitals, both of which would involve new challenges.

Finally, cutting across the domains of clinical practice, medical education, and administrative leadership, Stephen Klasko, MD, MBA, responds to an interviewer's questions about the current and future roles of leadership and team-based care in medicine in the podcast. You will notice, as you read this issue of *Virtual Mentor*, that I have tried to practice what the issue preaches—many articles are collaborations among professionals from disparate health care fields. If we are to improve health care for our patients, cross-specialty dialogue will continue to be of the highest importance.

Jennifer Chevinsky

MS-3

University of South Florida Health Morsani College of Medicine, SELECT Program  
Tampa, Florida, and Allentown, Pennsylvania

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# Virtual Mentor

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## ETHICS CASES

### Team Response to Internal Disagreement about Professional Conduct

Commentary by Robert M. Walker, MD

Mr. Berkley is a physical therapist on a home-based primary care (HBPC) team. The HBPC team is multidisciplinary, with independent practitioners who visit patients in their homes. The team meets weekly, and is composed of physicians, nurse practitioners, physician assistants, physical therapists, respiratory therapists, social workers, dietitians, and nondenominational members of the clergy. The team's leader, Dr. Miller, is a specialist in geriatric medicine.

When the team learned that one of their patients, Mr. Noland, was not adhering to his prescribed regimen of antipsychotic medication, the team members worked diligently with him, explaining the medication's importance and encouraging him to take it, but his adherence remained spotty.

At a recent team meeting, Mr. Berkley, a physical therapist, cheerfully reported that Mr. Noland had become much more consistent with taking his antipsychotic medication. However, other team members did not seem pleased by this news. A few of them had seen Mr. Berkley taking small gifts, meals, and groceries to Mr. Noland's house. They believed this violated professional boundaries. Other team members noted that Mr. Berkley and Mr. Noland shared the same religion and surmised this might be motivating Mr. Berkley to give special attention to Mr. Noland. The team members discussed their concerns, with most concluding that Mr. Berkley's conduct was inappropriate and set the wrong example for patient care. They recommended that Mr. Berkley be removed from Mr. Noland's case. Mr. Berkley responded that his care had led to Mr. Noland's improved adherence to his medication regimen.

After the meeting, Dr. Miller decided to investigate by making a visit to Mr. Noland's house. Dr. Miller confirmed the allegations discussed at the team meeting. She mentioned to Mr. Noland that Mr. Berkley might be assigned to another client. Mr. Noland was upset by this and threatened to stop taking his medication if Mr. Berkley stopped visiting.

### Commentary

This case involves serious conflict within an interdisciplinary team. The conflict centers on the behavior of the physical therapist, Mr. Berkley, who has achieved an important team goal, that of getting the patient, Mr. Noland, to take his antipsychotic medication consistently. However, Mr. Berkley appears to have done this at the expense of the team, which has become troubled to the point of recommending that

he be removed from Mr. Noland's case. This conflict raises several questions. Is this a conflict over Mr. Berkley's practice style or is it an actual breach professional boundaries? How might Mr. Berkley's actions have changed Mr. Noland's expectations for other members of the team? Is it appropriate for team members to make this judgment, or should it instead come from the team leader? How should we characterize Mr. Berkley's potential conflict of interest? And finally, how should these issues be resolved?

### **Practice Style versus Violation of Professional Boundaries**

Is Mr. Berkley's behavior a matter of practice style or does it violate professional boundaries? The team alleges that Mr. Berkley's "conduct was inappropriate" and that it "set the wrong example for patient care." Mr. Berkley, on the other hand, insists that he has provided "care that led to Mr. Noland's improved adherence to his medication regimen." Which is it? First, it appears that Mr. Berkley's practice style is highly personable. This is clearly an asset that has enabled him to forge a relationship, which has been instrumental in getting Mr. Noland to take his medicine consistently. However, what troubles the team is not Mr. Berkley's personable style; it is the extra attention he bestows upon Mr. Noland in the form of gifts, meals, and groceries.

Gift giving of any sort lies within the personal domain, outside the professional boundaries of even the most personable clinician. Our obligations as professionals require us to stay in the professional role as much as possible. To do this, a professional needs to limit his or her activities to things that pertain to direct clinical care. Exceptions may occur when personal and professional relationships inescapably blur, such as in rural communities, but that is not the case here [1].

Meals and groceries can also be categorized as gifts, but providing them may instead represent an attempt to meet a legitimate need. If Mr. Noland lacks sufficient food, Mr. Berkley should have enlisted the expertise of the team social worker so that resources could be identified and accessed as needed. Instead Mr. Berkley chose to provide meals and groceries, bypassing his colleague, team protocols and conventional professional boundaries.

### **Changing Expectations for Care and Team Dynamics**

How might Mr. Berkley's actions change Mr. Noland's expectations for care from other members of the team? Since Mr. Noland receives special attention and gifts from Mr. Berkley, he might expect other team members to treat him the same way and view them in a less favorable light if they didn't. This raises the question of whether the other team members will receive less favorable patient satisfaction surveys from Mr. Noland for staying within professional boundaries, which may, in turn, negatively impact their careers. Team members may resent Mr. Berkley for putting them in this position, which could have been avoided had he stayed within professional boundaries. In short, situations like this can sour intrateam relationships, which will negatively affect team function. Therefore, it is imperative that the situation be resolved in favor of restoring the team's functional balance.

### **The Ethics of Interdisciplinary Teams' Decision-Making Procedures**

Is it appropriate for team members to make a judgment that Mr. Berkley violated professional boundaries, or should such a determination come from the team leader? To answer this, we need to look briefly at the ethics of interdisciplinary teams. The core virtue of the team is mutual trust [2]. The team has to be able to trust that each member knows, values, and respects each discipline's role and functions. When trust is broken either through professional boundary violations or by bypassing a team member, the team becomes compromised.

In HBPC and other interdisciplinary team practices, the individual professional is replaced by the team [3]. The result is a team-patient relationship, not merely a group of individual professional-patient relationships. For the team to be most effective, and therefore benefit the patient most, it must function as an interdisciplinary unit. When individual members disrupt team unity, the team's effectiveness becomes compromised. In Mr. Berkley's case, he has cultivated a special relationship with Mr. Noland, which, though helpful in achieving the team's goal of medication adherence, has critically disrupted the team, making it less effective. It seems he has allowed his professional-patient and personal relationships to eclipse the team-patient relationship.

So is it appropriate for team members to make the judgment that Mr. Berkley has violated professional boundaries? Yes. Each member of the team has an equal stake in the effectiveness of the team as a whole, so it is appropriate to handle such matters democratically. If a team member's behavior causes conflict within the team, the team has a responsibility to self-monitor and correct any perceived imbalance. If the team is not able to correct the situation collaboratively, the team leader, Dr. Miller, must intervene.

### **Exploring Conflicts of Interest**

Apart from generating conflict within the interdisciplinary team, Mr. Berkley may also have a conflict of interest. As a physical therapist, his primary fiduciary interest is to provide good physical therapy for Mr. Noland. As an interdisciplinary team member, he has an interest in the quality of care provided by the team as a unit. However, he also appears to have a third unidentified personal interest that has led to gift giving and resulted in intrateam conflict.

In exploring this personal conflict of interest, some consideration should be given to possible motivations for Mr. Berkley's behavior. First, is this how he treats all of his patients? Or is there something special about Mr. Noland? It has been noted by many of the team members that Mr. Berkley and Mr. Noland share the same religion. Is Mr. Berkley showing faith-based favoritism, or is he simply being generous? Is his faith interest conflicting with and compromising his interest in good team care and commitment to professional boundaries?

Second, is Mr. Berkley gloating with his cheerful announcement that Mr. Noland had become much more consistent with taking his medication? Is Mr. Berkley exhibiting

passive-aggressive behavior toward his own team members by working outside of team and professional boundaries? Is he hoping to ensure that Mr. Noland gives him patient satisfaction ratings that exceed those given to the other members of the team? If so, he may be letting his own self-interest, or more properly, self-aggrandizement, take center stage. There is much that needs to be explored here. The team leader, Dr. Miller, needs to gain insight from other team members about these matters, as well as from Mr. Noland.

### **Working toward a Resolution**

The first step toward resolution of intrateam conflict should take place within the team, as it has here. Team members communicated their concerns directly to Mr. Berkley and invited him to respond. If the conflict cannot be resolved at the team level, Dr. Miller would need to take further steps. She will need to meet privately with Mr. Berkley. She will also need to meet with the other team members, either separately or as a group. She may also need to take the step of meeting directly with the patient, as she does here by visiting Mr. Noland.

Once the allegations regarding Mr. Berkley's actions are confirmed, Dr. Miller could choose to remove Mr. Berkley from the case. However, if Dr. Miller determines that Mr. Berkley's behavior is a one-time exception to an otherwise consistent record of professionalism—especially if Mr. Berkley explains that he was trying anything and everything to get Mr. Noland to take his medications—she might also decide to allow him to continue to care for Mr. Noland with the proviso that no further gifts or food be given. If Dr. Miller determines that Mr. Berkley is showing faith-based favoritism toward Mr. Noland, or is engaging in self-aggrandizing behavior, or both, she should counsel Mr. Berkley to stop the behavior immediately. She should explain why the behavior violates professional norms and boundaries and highlight the disruptive effect it has on the team. In the event that Dr. Miller concludes that Mr. Berkley's actions are part of a larger pattern of behavior that has caused intrateam conflict in other cases, she should strongly consider removing Mr. Berkley from the team altogether.

Though Mr. Noland threatened to stop his medication if Dr. Miller removes Mr. Berkley from his care, this should not affect Dr. Miller's decision. Dr. Miller has an ethical responsibility to restore balance and effectiveness to the team. If she decides to remove Mr. Berkley from Mr. Noland's case or from the team, she should explain to Mr. Noland that the team is there for his benefit, that optimizing his health includes adhering to the medication regimen, and that stopping his medication would only hurt himself. For Dr. Miller to capitulate to Mr. Noland's threat and keep Mr. Berkley involved with no behavior change would not only be to let Mr. Noland manipulate her but would constitute a failure as significant as any exhibited by Mr. Berkley. It would allow a compromised team to continue to give compromised care.



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Robert M. Walker, MD, is an associate professor of medicine and the director of the Division of Ethics, Humanities, and Palliative Medicine at the University of South Florida Health Morsani College of Medicine in Tampa.

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## Related in VM

[Competitiveness Can Undermine Team Goals](#), May 2009

[Transitions of Care: Putting the Pieces Together](#), February 2013

[Perceptions of Teamwork in the OR: Roles and Expectations](#), January 2010

[Leadership and Team-Based Care](#), June 2013

[Hierarchical Medical Teams and the Science of Teamwork](#), June 2013

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# Virtual Mentor

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## ETHICS CASES

### **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].

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Erin L. Bakanas, MD, is an associate professor of internal medicine and associate director of the Bander Center for Medical Business Ethics at Saint Louis University School of Medicine in Missouri. She teaches medical ethics to medical students and residents and serves as chair of the Saint Louis University Hospital ethics committee. She works in a general internal medicine practice where she enjoys collaborating with two advanced practice registered nurses.

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# Virtual Mentor

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## ETHICS CASES

### Approaching Interprofessional Education in Medical School

Commentary by Dawn M. Schocken, MPH, Amy H. Schwartz, PharmD, BCPS, and Frazier T. Stevenson, MD

A U.S. medical school has decided to embrace the current health care changes and incorporate exposure to interdisciplinary teamwork into its medical curriculum. As a part of this mission, medical, pharmacy, nursing, and physical therapy students gather for interdisciplinary events a few times throughout the year. The students, all in their second year of studies, are instructed to conduct an interview with a standardized patient and decide on an assessment and plan.

In the spirit of camaraderie, the course directors encourage students from all disciplines to take turns being the consult leader. After a few sessions, many of the medical students begin to approach the course director with concerns, questioning the relevance of this program, inasmuch as they will more often be the leaders and coordinators of a team. They have suggested changing the program to keep the medical students as the consistent consult leaders.

On the feedback surveys, one of the medical students remarked, “we should be trained to be doctors, the nursing students should be trained to be nurses, and the pharmacy students should be trained to be pharmacists. I don’t understand how sitting back and letting the other disciplines lead the consultation helps us with realistic teamwork.”

### Commentary

The delivery of high-quality care is a complex endeavor at every health care institution [1]. The rising costs of health care delivery, the complexity of caring for the patients with multiple chronic diseases in an aging population, the myriad choices available in drug and therapeutic managements, and the changing landscape of health care policy together necessitate that physicians be trusted and able team leaders as well as competent clinicians. We have seen leadership training in the business realm for several decades, but the trends in health care just mentioned have recently led academic institutions to realize the importance of educating for leadership in medicine, education that would teach students to recognize and develop strategies for managing the complexities of comprehensive patient care in our strained economic environment.

Literature on leadership in the academic setting points to communication, visioning, strategic planning, change management, team building, personnel management, business skills, and systems thinking as critical skills for the physician leader [2].



Strong leaders are those who can establish positive and trusting relationships and who are as aware of their weaknesses as of their strengths, which encourages them to develop complementary teams that can grow to create optimal patient care delivery.

The emphasis on teamwork in health care increased significantly after the publication of two reports from the Institute of Medicine (IOM) that illustrated quality problems in U.S. health care and called for vastly improved teamwork to help stem the tide of medical errors and preventable conditions [3, 4]. Given the essential need to develop functioning teams, medical education responded with leadership skills and teamwork competencies for training clinicians. At first, the marriage between understanding good leadership and the need to create optimal teams perpetuated a hierarchical model in which the physician leader retained legal responsibility for patient care. A business model of leadership was the basis for physician practice as part of a team, though still as its leader. One of the challenges of this model is that, in practice, team members are ill prepared to manage problems inherent in the hierarchical system. Rarely do team members have the communication training needed to resolve the inevitable tensions that arise over conflicting opinions in patient care. Doctors, nurses, pharmacists and others have different training; clear conflicts arise from their varying expectations about outcomes and individual members' roles and responsibilities.

In 2007, the Association of American Medical Colleges (AAMC) released its strategic priorities to their membership; clearly stating that interprofessional education (IPE) and interprofessional practice (IPP) were key areas of focus [5]. Following this release, many medical schools began to actively incorporate some form of IPE into their curricula to prepare their students for the future of health care in a patient-centered, team-oriented system. [6]. When trying to engage in authentic IPE opportunities in a traditional medical model, many schools merely placed learners from many health care disciplines in the same place at the same time, with little regard to how the students would conceptualize a workforce that functioned in an IPP fashion. This is the situation expressed in our case scenario.

In May 2011, six national associations of schools of the health professions published the Core Competencies for Interprofessional Collaborative Practice [7], which emphasized the importance of understanding the roles and responsibilities of one's own profession first and foremost. Following that, professionals should, the report said, gain knowledge of the roles and responsibilities of *all* health care professionals with whom they will interact. This knowledge base was thought to be fundamental to the later creation of open dialogue about patient-centered, team-based care.

A 2012 review of IPE literature in *Academic Medicine* highlighted several instances of seminal work in Interprofessional education. Among these was a review of leadership in IPE in academic medical education [8]. The authors concluded that, "although physician leadership is not problematic in and of itself, we have found that it raised many issues within Interprofessional teams" [9]. Emerging discussions of clinical democracy and how to overcome ingrained incentives for maintaining

structural hierarchies seemed to open doors for reflection about leadership and collaborative practices.

The vicissitudes of patient care are demanding change in practice modes, and reimbursement structures and health care policy will dictate terms of delivery that require physicians to collaborate with their peers. Even as teamwork becomes the new standard of care, however, responsibility for the continuity of care continues to reside with the physician, who maintains and manages communication with the patient. It is within this structure that medical schools have responded to the need to train physicians for collaboration. The dichotomy in which the physician must be the repository of the patient's care and information, while working collaboratively to achieve better patient outcomes, leaves most traditional medical educators struggling to offer authentic educational experiences to prepare the physician caregiver to work in a team while retaining the leadership role when the care for the patient dictates.

There have been contradictory findings about the effectiveness of health care teams, but these may relate to the actual structure of a team—loose or formal—and the nature of decision-making—hierarchical or egalitarian [10]. The nature of IPE programming allows the medical schools to introduce a collaborative orientation [11], meaning that members of the health care team will work in an egalitarian rather than hierarchical fashion, even in the absence of formal team structures. This new teamwork frame allows for fluidity of roles in the team setting and lends itself to a patient-centered, collaborative care model.

### **Possible Approaches to Interprofessional Education**

Such an approach to leadership, however, can be challenging for IP teams embedded in traditional health care, educational, and medical-legal systems that reinforce the idea that physicians sit at the top of the hierarchy. Effectively implementing IPE into the various curricula in health care takes coordination and planning on the part of all the educators. A commitment on the part of the health care institutions to training their faculty in IPE methodology is critically important in most institutions, as is developing institutional strategy for ensuring the viability and sustainability of all IPE initiatives.

The academic health science center in our case scenario might find it helpful to institute collaboration in clinical patient care first, as one method of assuring the IPE pedagogy is implemented. Course directors could align themselves with IPE-trained faculty to bring the various skills needed for collaborative work into their programs. Seeing a fluid model demonstrated by faculty will foster greater appreciation of both the similarities between professional responsibilities in the health care environment and the complexities they will face when practicing themselves. And having the faculty work side-by-side can allow the faculty to model behaviors to their students.

A second, less faculty-intensive, approach is developing case-based scenarios that reflect the roles and responsibilities of a broader health care team and giving students an opportunity to practice with guidance prior to engaging in real clinical care. The

challenge has been set and the patients are demanding a more unified team approach, but to develop and roll out any version of this curriculum takes much thought, active coordination, and alignment in perceptions and principles of practice.

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Dawn M. Schocken, MPH, is director of the Center for Advanced Clinical Learning and chair of the interprofessional education committee at University of South Florida Health Morsani College of Medicine in Tampa. She is interested in enhancing health professional students’ education through simulation and experiential learning.

Amy H. Schwartz, PharmD, BCPS, is the associate dean for curriculum development at the University of South Florida Health College of Pharmacy in Tampa. She is an active member of the USF Health interprofessional education committee and is interested in evaluation of students’ learning.

Frazier T. Stevenson, MD, is the associate dean for undergraduate medical education at the University of South Florida Health Morsani College of Medicine in Tampa. His research on the effects of interprofessional education on preclinical learners is funded by the Arthur Vining Davis Foundation.

**Related in VM**

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# Virtual Mentor

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## MEDICAL EDUCATION

### **Fostering Emotional Intelligence in Medical Training: The SELECT Program**

Alicia D.H. Monroe, MD, and Allesia English, MD, PharmD

Physicians' emotional intelligence (EI)—how they manage themselves (i.e., emotions and behavior) and their relationships—has significant influence on team-based care. It can support empathy and improved communication between team members and promote shared decision-making, conflict management, and improved transitions between care settings. Furthermore, physician leaders are working in rapidly evolving systems and must respond to increasing and changing demands. EI correlates significantly and positively with job performance beyond that which can be explained by cognitive ability and other personality factors [1]. Top-performing leaders are distinguished by their ability to manage their emotions and effectively share their visions and influence others [2]. Emotionally intelligent leaders are more effective in fostering cooperation and initiating and leading organizational change [3, 4]. Cultivating EI and habits of mind can build resilience and altruism, support well-being, and nurture professional relationships.

With this in mind, the University of South Florida (USF) Morsani College of Medicine in Tampa and Lehigh Valley Health Network (LVHN) in Allentown, Pennsylvania, established a partnership to create a new program to train health care leaders. The program is entitled SELECT, an acronym for Scholarly Excellence, Leadership Experiences, Collaborative Training. Students complete all the general competencies and also receive training in leadership development, patient-centered care, health systems, teamwork, and care quality and safety. Students complete the first 2 years at USF and the last 2 years at LVHN, where they apply leadership, teamwork, and quality and safety competencies during their clinical training.

### **Choosing a Leadership Model**

In developing SELECT, we reviewed the literature, consulted with health care leaders and experts, and considered measurement instruments. There are multiple definitions of EI with associated theoretical models and measures. The ability model of EI defines EI as a set of four interrelated abilities or traits: accurately perceiving emotions; using emotions to influence thoughts; understanding emotions; and managing emotions (e.g., anger). Behavioral EI models incorporate abilities and characteristics [5-7].

We use Goleman's behavioral EI model, which has four domains of competency: (1) self-awareness—recognizing one's own feelings, values, strengths, limitations, and motivations; (2) self-management—emotional self-control, adaptability, initiative, optimism; (3) social awareness—empathy, organizational awareness, and orientation

to service; (4) relationship management—influence with others, management of conflicts, teamwork, and collaboration. Self-awareness serves as the foundation for self-management and social awareness, and all three serve as the foundation for relationship management [8]. We elected to build our leadership training on a behavioral model of emotional intelligence (EI) because it is competency-based, is developmentally appropriate for novice professionals who are early in their training and not in formal leadership roles, and enhances other competencies and skills germane to medical education and practice.

We also elected to use a validated instrument to formally assess EI at multiple points during the students' medical education. We chose the Emotional and Social Competence Inventory (ESCI), a validated survey instrument developed by Richard Boyatzis, Daniel Goleman, and the Hay Group based on Goleman's model of EI [9]. We use the ESCI to measure students' emotional and social competencies and provide feedback to raise their awareness of developmental needs and opportunities. The leadership curriculum is co-created and team taught with our colleagues from the TELEOS Leadership Institute.

### **Emotional Intelligence in the Admissions Process**

The aim of the SELECT program is to train leaders, and we seek to recruit students with interest in leadership and some evidence of EI. We use a holistic review process for the initial review of all applicants including their experiences, attributes, and academic achievement. To assess EI during the interview visit, we use a 90-minute behavioral event interview (BEI). The BEI is a semi-structured interview method based on the critical incident interview [10] in which trained interviewers ask a sequence of questions to explore specific salient events from the candidate's life [11, 12]. The questions are designed to probe so deeply that the student cannot rely upon rehearsed answers and superficial descriptions of an event. Overall, we have seen high congruence between the ratings of the two interviewers. Students are offered admission to the SELECT program based on these ratings. We have admitted two cohorts of students to the SELECT program and are interviewing for the class of 2017.

### **Overview of SELECT Leadership Training**

At the start of medical school, students begin the longitudinal leadership curriculum with an intensive 5-day immersion course that introduces EI concepts and competencies through small-group experiential learning activities, debriefing, journaling, and peer coaching. Students meet with two physician faculty member coaches who will coach them individually and in cohorts throughout the 4 years on their personal, professional development plans.

*Curriculum.* Each year, students receive incremental exposure to skills of self-awareness and self-management in clinical work, crucial conversations (high-stakes, emotionally charged discussions between two or more people in which opinions differ), conflict management, mindfulness, leadership and learning styles, power and influence, and team dynamics. In year 2 there is added emphasis on high-functioning

interprofessional teams, a peer coaching practicum, and a health care leader interview and shadowing experience. The curriculum expands to include change management, quality improvement, and project management in years 3 and 4. The teaching methods include learning modules, self-directed learning exercises and reading, individual and small group assignments, and health care leader shadowing.

*Evaluation.* Early in the first year, and again at the end of the second year, students complete the Emotional and Social Competency Inventory (ESCI) administered by certified coaches. Students receive feedback on how their peers, faculty, and administrative team members perceive their application of EI competencies. Other assessment strategies for leadership and EI training include project presentations, reflective writing, measurement of achievement of professional and personal development benchmarks and milestones, and performance on simulated and small-group exercises.

### **Lessons for EI in Medical Education**

We recommend that medical schools interested in fostering EI in their students develop faculty advocates and create a solid EI knowledge base and a vision for short-term and long-term success. First—find champions: identify emotionally intelligent faculty and practitioners with good communication skills, self-management skills, and healthy relationships. Second—build a strong knowledge base: engage knowledgeable experts to teach EI concepts, competencies, and strategies to participants. Third, create a vision for success—how will you roll out and sustain your initiative? There are a variety of curricular and co-curricular approaches to consider. Consider offering curriculum innovation grants, planning a retreat for students and faculty, or hosting a faculty development activity. Engage and involve students and faculty in deciding which courses, programs or activities you will use to bring your EI initiative to life.

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Alicia D.H. Monroe, MD, is a professor of family medicine, chief academic officer, and vice dean of educational affairs at the University of South Florida Health Morsani College of Medicine in Tampa.

Allesa English, MD, PharmD, is the director of the SELECT Program preclinical curriculum and the director of the MD advising program at the University of South Florida Health Morsani College of Medicine in Tampa.



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# Virtual Mentor

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## THE CODE SAYS

### **The AMA *Code of Medical Ethics*' Opinion on Physician Administrators**

#### **Opinion 8.02 - Ethical Guidelines for Physicians in Administrative or Other Non-clinical Roles**

The practice of medicine focuses primarily on diagnosis and treatment of disease and injury, but its concerns extend broadly to include human experiences related to health and illness. Throughout their formal education and their practice of medicine, physicians profess and are therefore held to standards of medical ethics and professionalism, such as those expressed in the *AMA Code of Medical Ethics*. Complying with these standards enables physicians to earn the trust of their patients and the general public. Trust is essential to successful healing relationships and, therefore, to the practice of medicine.

The ethical obligations of physicians are not suspended when a physician assumes a position that does not directly involve patient care. Rather, these obligations are binding on physicians in non-clinical roles to the extent that they rely on their medical training, experience, or perspective. When physicians make decisions in non-clinical roles, they should strive to protect the health of individuals and communities.

Issued June 1994 based on the report "[Ethical Guidelines for Medical Consultants](#)," adopted December 1992; updated November 2007 based on the report "[Physicians in Administrative or Other Non-clinical Roles](#)," adopted June 2007.

#### **Related in VM**

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[Assignment, Attribution, and Accountability: New Responsibilities and Relationships in Accountable Care Organizations](#), May 2012

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## Virtual Mentor

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### JOURNAL DISCUSSION

#### Leadership of Accountable Care Organizations

Primi Ranola

**Kocher R, Sahni N. Physicians versus hospitals as leaders of accountable care organizations. *N Engl J Med.* 2010;363(27):2579-2582.**

The Affordable Care Act (ACA) of 2012 brought about the greatest change to health care delivery in the U.S. since the enactment of Medicare and Medicaid in 1965. The ACA seeks to improve quality of care and reduce costs mostly stemming from overuse of tests and treatments, unnecessary hospitalizations, and avoidable complications. Additionally, it promises to usher in a period of overhaul during which the fragmented fee-for-service health care delivery system becomes transformed into a higher-quality system through strong incentives for efficient, coordinated care. During this critical time of transformation, the interplay between physicians and hospitals will determine the structure of health care delivery and the success of the ACA's vision for many years.

In "Physicians versus Hospitals as Leaders of Accountable Care Organizations," Robert Kocher and Nikhil Sahni describe how implementing accountable care organizations (ACOs) will reduce excesses inherent in the fee-for-service system. They argue that the current problematic structure of health care funding, involving a combination of employer-based coverage and Medicare and Medicaid, has come about because of what they call "path dependence," a vicious cycle in which decisions about the future are constrained by decisions made in the past despite changing circumstances. The fee-for-service system that still dominates health care (outside HMOs and managed care organizations) involves getting each part of our medical services separately. ACOs, on the other hand, integrate different components of patient care such as primary and specialist care, hospital care, home health services, and hospice. ACOs will incorporate primary care practices structured as patient-focused medical homes, support new IT systems and care teams, and provide expanded service hours similar to that of vendors [1]. Importantly, public (i.e., government) and private insurers will share cost savings from better coordinating patient care. The crucial remaining question is: who will run the ACOs? The two natural frontrunners, physicians and hospitals, each have obstacles to overcome.

If doctors are to be in control of ACOs, they will need to master not only clinical but administrative and fiscal collaboration skills. Physicians are not typically known for their administrative and team-building skill set, however. Moreover, nearly 75 percent of all office-based physicians (which account for 95 percent of all U.S. practices) work in groups of five or fewer, very unlike the large group collaboration

needed to successfully operate an ACO. Since much of the savings from coordinating care will come from successfully eliminating tests, procedures, and hospitalizations, the sharing of savings by primary care physicians and specialists will be an issue of debate. The specialists who would end up losing income are likely to resist these structural changes [2].

Conversely, if hospitals are to employ physicians and run ACOs, they will need to shift focus from being profitable by concentrating on procedures and severely ill patients to turning profits from coordinated outpatient care. Hospitals have struggled to operate outpatient services effectively in the past, which does not augur well for their success in designing ACOs [3]. Furthermore, hiring doctors as mere employees commonly reduces physicians' motivation to work longer hours, causing them to accomplish less [3].

Kocher and Sahni recognize that whoever ends up taking the lead in establishing ACOs will retain a majority of the shared savings. It is unlikely that either hospitals or physicians will predominate across the country, since local market conditions will determine which one prevails in which community. The player who strikes first and most effectively is likely to build momentum and dominate the local market, gaining access to other untapped markets [4].

It would be helpful for the authors to elaborate on the delicate interplay involved in having physicians and hospitals work *for* one another. The employee-employer relationship is more paternalistic than the traditional hospital-physician relationship, so, if hospitals assumed leadership of ACOs, having doctors in subordinate positions without sacrificing quality of care would be a challenge that may be beneficial to map out. If doctors headed ACOs, self-referrals might reduce the overall number of hospitals and their attendant financial and community influence and activity [4].

Like Kocher and Sahni, I think it would be interesting to see physicians take the lead on this reform. In the early twentieth century, the health care system changed dramatically when hospitals gained authority as they became associated with hope and health, rather than fear and death, thanks to the advent of antisepsis and the increasing safety and success of surgery [4]. Now we are at another junction, and, after decades of hospital ascendancy, doctors have the chance to assert greater control and promote prevention, reduce specialty referrals, and minimize exacerbations of chronic illness.

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Primi Ranola is a master's degree candidate in Northwestern University's program in medical humanities and bioethics. She is a graduate of the University of Rochester and an intern for the American Medical Association Council on Ethical and Judicial Affairs in Chicago.

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# Virtual Mentor

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## HEALTH LAW

### Scope of Practice in Team-Based Care: Virginia and Nationwide

Valarie Blake, JD, MA

Fueled by the need to control escalating health care costs and provide better and more coordinated patient care, proposals for reforming the way medical care is delivered and paid for in the U.S. emphasize team-based approaches. The Affordable Care Act of 2012 (ACA), for example, proposes the establishment of accountable care organizations (ACOs) [1]—groups of physicians, hospitals, and other providers who join together to provide cost-conscious, quality, coordinated care to patients. With increased collaboration and shared responsibility among different specialties and professions, however, come new legal challenges, particularly in the area of physician liability and antitrust regulation. Virginia recently addressed some of these challenges by passing a law that promotes team-based care and serves as an excellent model for how physicians and nurse practitioners (NPs) can better collaborate.

#### Virginia Law on Team-Based Care

This law on team-based care represents a statewide legislative effort to guide physicians and other health care professionals in team-based practice [2]. With battles between NP and physician groups over the extent to which NPs can practice independently and a doctor shortage affecting two-thirds of the state, the Virginia law reflects a compromise that centers on patient well-being [2]. The law, which went into effect in July 2012, maximizes NPs' roles in the health care team [3, 4]. Specifically, the law shifts the role of physicians from supervisors of NPs to leaders of health care teams [3, 4]—the language was changed from requiring an NP to practice “under the supervision of a duly licensed physician” to “in collaboration and consultation with a patient care team physician” [3]. Still, “nurse practitioners shall only practice as part of a patient care team” [3].

At the same time, physicians supervise a greater number of NPs (from four to six) and can do so remotely [3, 4]. All team members must have clearly defined patient care roles, there must be appropriate collaboration between NPs and physicians, and certain administrative burdens related to hiring and maintaining NPs are reduced [3, 4]. Collaboration includes “communication of data and information about the treatment and care of a patient, including exchange of clinical observations and assessments” and “development of an appropriate plan of care including decisions regarding health care provided, accessing and assessment of appropriate additional resources or expertise, and arrangement of appropriate referrals, testing, or studies” [3].

The Virginia law is a decisive step toward establishing legal standards for team-based care, but, notably, the law does not address a variety of significant legal issues raised by team-based care and ACOs, including physician liability, billing, and whether collaboration between certain clinicians violates antitrust laws.

### **Medical Malpractice and Physician Supervision**

Physicians who are able and willing to delegate patient education and certain counseling and protocol-based services (meaning services with very clearly defined protocols and no need for clinician judgment) to nonphysician staff are able to care for more patients [5, 6]. And primary care provided by NPs has been shown to be as safe as that provided by physicians [7]. Yet there are legal limits on independent practice by NPs, particularly at the state level. Twenty-two states require NPs to operate under a collaborative agreement with a physician [8]. Sixteen states allow for full practice, meaning that a state nursing board rather than a physician monitors the NP's evaluating, diagnosing, and managing of treatments and prescribing of medications [8]. A minority, 12 states, require supervision or team management by a physician [8].

Team-based care models impact physicians' roles as supervisors by, as in Virginia, increasing the number of NPs a physician can be responsible for. This can in turn have implications for medical liability. In some legal scenarios one party may be liable for another person's illegal actions (for example, a corporation might be liable for the wrongs committed by its leaders); this is known as vicarious liability. One specific type of vicarious liability is the legal theory of *respondeat superior*, which holds bosses and employers accountable for the conduct of their employees [9]. A deciding factor in such legal cases is the degree to which the employer has control over the actions and work of the employee [9]. Physicians have long faced legal responsibility for the actions of their trainees and employees under this theory and the new law in Virginia has not changed physicians' role as leaders, and, thus, they are most likely to continue to shoulder medical liability.

Liability in collaborations among physicians within an ACO may also be somewhat uncertain. The ACA does not provide a clear standard for medical liability for physician participants in ACOs, but physicians have been held accountable in malpractice cases for rationing care even when they were following managed care organization orders to do so [10]. Physician liability in the ACO context could be similar. Even though ACOs are intended to improve the quality of care, they are also intended to contain cost, and organizations' goals in that regard might not match the goals of individual physicians. Physicians sued in the court system for medical malpractice will face the testimony of expert peers on what the standard of care ought to be, rather than what evidence-based medicine or the ACO might indicate [10, 11].

ACOs and team-based units, as a whole, may also be held accountable for medical liability according to the theory of direct corporate negligence, which entails a duty to select competent caregivers, oversee their care, and adhere to policies that ensure

quality care [10]. Alternatively, they could be held accountable under vicarious liability or *respondeat superior*, mentioned above, in which case they are liable for the negligence of their contracted physicians, just as the boss of a company can be held accountable for the actions of its employees [10].

### **Anti-Competitive Practices**

Physician practices, like other forms of business, can raise concerns about antitrust and anti-competitive practices [12]. These laws protect competition among businesses under the theory that if any single entity controls too great a portion of the market it can use its power to fix prices. The goals of ACOs and team-based care are similar to those that underlie antitrust and anti-competition laws: to lower cost, promote innovation, protect consumers, and maintain quality [12]. However, by virtue of joining physicians and institutions who were formerly competitors in the same geographic area, ACOs must be careful to do so without violating these laws [12]. The ACA does not provide specific guidance, but collaborations in health care are not unique, and the Federal Trade Commission and Department of Justice have provided guidelines in other contexts on how to collaborate in health care without violating antitrust laws [13].

In sum, then, ACOs and team-based care create a need for new regulation. State-by-state responses will continue to develop in both the courts and the legislature as team-based care increases.

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Valarie Blake, JD, MA, is a senior research associate for the American Medical Association Council on Ethical and Judicial Affairs in Chicago. Ms. Blake completed the Cleveland Fellowship in Advanced Bioethics, received her law degree with a certificate in health law and concentrations in bioethics and global health from the University of Pittsburgh School of Law, and obtained a master's degree in bioethics from Case Western Reserve University. Her research focuses on ethical and legal issues in assisted reproductive technology and reproductive tissue transplants, as well as regulatory issues in research ethics.

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# Virtual Mentor

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## POLICY FORUM

### Creating Incentives for Accountability in Patient Care

William Bond, MD, MS

“If we all put one of our lunch items in a pool, then we can sell them, and we’ll split the profit.” This must be heard in middle school lunchrooms across the country every year. The corporation usually lasts a few days and may end in a lunchroom brawl, but generally nobody dies or becomes permanently injured. As we consider the market for lunchroom dessert pastries, it highlights the many differences between health care and other goods. With pastries, we know the price on offer and the price if we bought the pastry at the competing corner store. We know our classmate is driven by the profit motive and is unlikely to share the income with his mother who packed the lunch. The profits are visible; the coins are easily seen, counted, and distributed. Thus, there is transparency in any gain sharing.

Of course in health care, we as the patient are not sure we want a pastry, we’re not told the price of the pastry, we’re not sure if the pastry is good for us, whether evidence exists that the pastry is beneficial, or whether the doctor is motivated to sell or withhold the pastry based on our well-being or his or her profit. Additionally, the doctor or practice might have avoided our lunch table all together, because we’re the poor kids or the kids who were likely to have a bad outcome after eating the pastry.

Thus in health care we have knowledge asymmetry, agency problems, lack of price transparency, and biased selection of patients, to name just a few issues. Adding to that complexity, Medicare, private insurers, and employers have now argued for incentives to increase care quality, decrease utilization, and improve overall outcomes [1]. Clearly patients, payers, and clinicians respond to incentives, and incentives in any system are challenging to orchestrate and can lead to distortions in the market. Consider the well described regional variation in health care utilization that is in part driven by the fee-for-service system [2, 3]. Any overly large incentive may distort the market or lead to unethical choices in the offering of services.

### Structuring Incentives Effectively for Teams and Organizations

Here we consider the impact of an incentive distributed on a team of providers, rather than simply on the individual physician. For any incentive to have an impact it must first be understood. In an era when incentives may be tied to clinician-, group-, and network-level performance, this should not be taken for granted. My multispecialty group within an integrated delivery system recently mandated an online training module to explain the incentive system and its impact on physician and advanced practice clinician salaries. As noted in informal discussions with colleagues, this module was felt to be appropriate and generally appreciated by

clinicians. Building an understanding of incentives for team members such as medical assistants with lower levels of baseline education, however, poses additional challenges. These team members may have difficulty understanding percentages, holdbacks, quintiles of performance, budget trigger points, and other terminology routinely used to justify or withhold incentives.

Without understanding, we cannot reach the goal of *aligning* incentives across the team. The focus of strategic alignment has traditionally been the relationship between physician incentives and those of an integrated health system [1]. However, within the integrated system, many team members such as nurses and medical assistants have key roles to play in meeting practice goals, but under current incentive structures receive little if any performance-based compensation. Some of the neglect may simply be a historical artifact of organizational structures, with nurses paid under a different reporting silo than doctors. Barriers may also be created by nursing union rules that inhibit trials of productivity-based pay or shared-risk models. In aggregate, more attention should be paid to incentives for other team members who play key roles in overall clinical productivity.

This is especially worth considering because the marginal impact of an incentive for any actor in the health care system will depend in part on its relationship to existing salary and wealth. Thus, reason would suggest that a \$5,000 bonus payout would be far more meaningful to a nurse making \$60,000 than to a physician making \$200,000. Incentives for lower-paid members of the team might actually yield significant productivity gains with smaller increases in cost than physician incentives. While executives may have 20 percent or more of their annual pay based on performance-based incentives, there are no authoritative guidelines or evidence about safe maximums or effective minimums of incentives for health care team members.

Furthermore, practice models can be set up so that performance markers must be met at the individual level, group level, and health network level. Whether these markers function independently—that is, when the individual performance marker is hit, the incentive for that marker is paid—or whether they are tied triggers—so that all marker levels must be hit for any reward to be had—must be carefully considered. Linking nothing to individual performance could be very frustrating, but linking all incentives to higher organizational level performance could be exceptionally demotivating. Reward structures demanding continuous progress can also be demotivating—most improvements in quality or cost are likely to plateau over time, and such incentives would lead to more effort for less marginal gain. Markers that target improvement over time may favor the clinician or team, while changes in absolute number may favor the hospital or health network, which typically receives and distributes the incentive [4].

Systems would do well to consider the balance of incentive between the inpatient and outpatient settings and between providers and staff. Likewise, markers that target improvement over time may favor the physician or team, whereas changes in

absolute numbers may favor the hospital or health network that typically receives and distributes the incentive [4].

### **What Behavior Is Being Incentivized?**

Which behaviors are encouraged by an incentive system are obviously worth considering as well. Ethical questions arise if the incentive becomes so strong that it creates selection bias within practices. By selection bias we mean potentially noncompliant or simply less healthy patients may be excluded so that the practice doesn't look bad on performance measures. There is some evidence that this happened in the National Health Service [5] which created the need for "exception reporting" allowing some patients to be left out of the incentive calculation. This was also found in Taiwan when there was "cherry-picking" with regard to which patients were chosen to be included in the performance tracking for diabetes [6]. In part, the success of the health maintenance organization (HMO) model, the system in which the provider shares the most risk for cost of care, stems from the fact that most non-Medicaid HMO patients are working individuals (or their families) with insurance, and thus the model excludes many high risk, high complexity patients. In the new ACO model, which is close to the HMO model in terms of shared risk and reward, team members may become complicit in patient selection bias if they are encouraged by strong financial incentives.

There are several solutions to problematic incentives. The Acute Care Episode (ACE) demonstration project capped provider bonuses at 25 percent of physicians' Medicare rate so that incentives would not be designed to grow or reduce patient volumes but to reward clear cost savings [7]. Another idea is to have some team members off any incentive plan, whether that incentive is to share cost savings or increase productivity. These team members can then serve as conflict-of-interest mediators and be available at the practice or integrated delivery system level. The idea is similar to appointing court judges so they can serve without need for reelection and are thus less beholden to stakeholders.

More work should be done to consider systems of arbitration that would mediate conflicts between those trying to decrease utilization and patients/advocates who feel that more care or diagnostic efforts are warranted [8]. Many such issues might be avoided by training physicians and educating patients in a shared decision-making process. Helping patients understand that the choice to recommend for or against testing is based on evidence rather than one doctor's opinion may lead to evidence-based care with less resource use and fewer adverse events [9]. Designing insurance schemes that motivate patients to both understand and choose value-added care will be another ongoing challenge [2].

### **Beyond Financial Incentives**

We must also acknowledge that financial incentives are only one factor affecting clinician behavior [10]. For an extensive review of the effectiveness of financial incentives in changing health care professional behaviors, see the Cochrane Review on this topic by Flodgren et al. [11]. Recent qualitative work by Bitton et al.

demonstrates both a method to study practice change and some of the impacts noted during practice change across multiple settings. Through a series of site visits and interviews they explored methods that were used to encourage change, including the role of consultants, team and staff restructuring, change fatigue, and the effects of compensation changes [12]. They found specific contextual factors in each practice that influenced the willingness to change a primary care practice to a patient-centered home model. In this case change to a PCMH meant shifting from a fee-for-service model to a capitated payment model that paid both the physicians and care team. It would be worthwhile to consider their research questions and methods before rolling out an incentive scheme, because the exploration of site-specific change barriers may allow for targeted and more successful change efforts.

In another ethnographic approach, Magrath et al. note that monetary and quality incentives might crowd out other sources of motivation such as intrinsic motivation, might undermine the social relationship with patients, and might have detrimental effects on teamwork by fostering competition or envy [13]. Nonfinancial incentives might include reward and recognition, but individuals may also be motivated by control over lifestyle and work flexibility. At the larger organizational level, characteristics such as organizational justice have been correlated with better performance [14]. Organizational justice, while manifested by fair policies and procedures, is ultimately rooted in ethically sound practice, professionalism, and model behavior. Thus, it is best to pay attention to both culture and nonmonetary incentives. Effective efforts to improve culture might include leadership development, accountability for highly professional behaviors, and fostering a focus on the patient.

In the end, the incentives of the U.S. health care system have to change to bring about system reform. For better or worse, the primary mechanisms of incentive reimbursement in accountable care organizations (ACOs) are likely to include bundled payments for episodes of care and pay-for-performance in the near future. Bundled payments should reward successful transitions of care efforts and appropriate reductions in utilization. Historically, however, capturing the value of managing complexity at the individual or practice level has been challenging. Utilization risk may force providers to reflect more carefully on care patterns beyond the individual patient and consider efforts such as those of the National Institute for Clinical Excellence (NICE) in the U.K. and “Choosing Wisely,” an effort of the American Board of Internal Medicine to deter low value practices through dissemination of evidence [15]. Already some have shown promising results with the ACO model focused on better coordination of care [16]. However, demanding accountability from clinicians and care teams when they may be hampered by incompletely orchestrated care delivery systems and fragmented electronic health records could be disheartening.

In conclusion, incentives and their distribution across the team and care settings must be carefully considered. Financial incentives should be considered as just one factor in clinician behavior change [10, 17-20]. Incentive targets should be agreed upon by

external stakeholders (patients, insurers, employers, and quality and safety leaders) and practice stakeholders (physicians, advanced practice clinicians, nurses, staff, and community or transitional care coordinators). The team will need education on the incentives, with periodic reinforcement and a process for indoctrinating new team members during orientation. The team's performance must be frequently fed back to its members and the team should use performance improvement methods to come up with collaborative ways to move toward performance goals.

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William Bond, MD, MS, is the designated institutional official, chair of the graduate medical education committee, and medical director for educational technology in the Division of Education, all at Lehigh Valley Health Network in Allentown, Pennsylvania. He is also a professor of medicine on the Clinical Educator Pathway at the University of South Florida Health Morsani College of Medicine in Tampa and a practicing emergency physician. He is interested in the use of simulation in improving patient safety and reducing cognitive error.

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### **Related in VM**

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# Virtual Mentor

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## MEDICINE AND SOCIETY

### **Hierarchical Medical Teams and the Science of Teamwork**

Ashley M. Hughes and Eduardo Salas, PhD

The current view is that medical students, residents, fellows, and doctors alike are taught to think, feel, and behave in ways that hinder participation in care teams. Medical students internalize the hierarchy as early as their undergraduate classes [1]. Rather than enhancing team performance, these internal power hierarchies diminish the effectiveness of these critical work teams.

Hierarchy in medical teams, as defined by Liberatore and Nydick [2], comprises a set of integrated levels within which members are ranked both by their disciplines and levels of authority. Attempts to assemble working groups can be hampered by problems in team cognition and cooperation, a lack of behaviors that foster teamwork, and poor coordination. Here, we will outline major contributors to team breakdowns in health care and then offer recommendations for being the key team advocate for patient care.

#### **What Is Teamwork?**

Medical teams include two or more people with shared goals and values [3, 4] who base their interactions on certain desired behaviors known as teamwork competencies [5]. More specifically, teamwork consists of the knowledge, skills, and attitudes that can inhibit or promote team progress in attaining shared goals. Essentially, these competencies fuel, drive, and explain the way a team behaves.

Over the past few decades, many attempts have been made to better understand teamwork [6, 7]. Major problems in hierarchical medical teams stem from deficits in team cooperation, coaching (efforts to foster teamwork), cognition, and coordination.

#### **Cooperative Spirit and Coaching**

Many medical teams' lack of cooperative spirit—the attitudes and beliefs that motivate team action—and coaching skills leads to conflict and tensions among staff. As an example of the lack of cooperative spirit in many health care teams, research on quality improvement initiatives such as implementation of a Rapid Response System reports physician resistance to change and ridicule of those using new systems [8, 9]. This lack of motivation to work together can hurt medical teams, making frontline clinicians less likely to admit the need for help and advocate for patient care [10].

Teams without effective coaching—actions team members take to foster positive social climate and improve performance (e.g., by giving feedback) [11]—fail to learn

from their mistakes [12]. Interprofessional rounds have been found to be necessary for cross-disciplinary care and vital to promoting patient safety [13]; however, evidence suggests that what should be participatory, collaborative exercises are heavily affected by hierarchy, dampening interdisciplinary exchange [14].

### **Cognition and Coordination**

Team cognition (when team members are on “the same page”) comprises knowledge of the ability and function (e.g., roles and responsibilities) of each team member and the ability to retrieve or act on this information while the team is in action [15]. There is evidence to document that teams that have shared cognition coordinate more effectively and efficiently, consequently leading to improved team performance [16]. Members of medical teams often lack knowledge of each other’s responsibilities [17], which can cause misunderstandings. A lack of team cognition makes the team unable to learn, self-regulate, and coordinate with other team members and other teams [7]. The ability to anticipate team members’ needs before it is communicated can greatly improve coordination and effective communication and create a safer, more effective team [18].

Coordination is the subsequent enactment of team shared cognitions [16]. More specifically, implicit coordination is coordination that utilizes shared mental models, a form of team cognition, to perform tasks and adapt to new situations without the need to communicate while working [19-21]. An example of a measure of failure in team coordination is increased time from decision to incision in an emergent cesarean section [22], which can result in adverse infant and maternal outcomes. The team’s enhanced coordination makes this improvement in patient safety possible by increasing the efficiency of the team in action. By fostering a punitive, power-driven social climate, medical hierarchy hinders team cognition and therefore effective coordination for patient care.

### **Building the Team**

*Promote team cohesion and collaboration.* As mentioned earlier, coaching refers to a team member’s efforts to support social climate, take initiative, and provide feedback and resources such as medical supplies or tools to the team [9]. This means involving other team members in decisions. Using coaching behaviors, such as structured, nonpunitive feedback, to foster a positive social climate can encourage the exchange of information necessary to learn, understand, and problem solve, despite difficulties in medical team hierarchies.

Feedback—seeking, providing, and receiving performance-related information (e.g., praise or positive criticism) [23]—is key to promoting collaboration. Feedback that is positively framed and timely and that emphasizes a behavior or process is most effective [24]. Team members should not be criticized, blamed, or personally attacked for their mistakes. This approach is intended to improve the way teammates interact, and more importantly, how they feel toward each other.

*Team debriefs.* Debriefs or after-action reviews are an effective technique [24] for reviewing a team's performance through reflection, planning, and discussion [25] after a performance session (e.g., surgery) to learn "from experience" [26]. Tannenbaum and Cerasoli [24] identified four key features of an effective debrief: active participation from all team members, a focus on developmentally improving team performance rather than assigning blame, discussion of specific events rather than general team performance, and information from at least two sources. These supportive processes encourage interprofessional collaboration and knowledge sharing and can reduce team conflict [27].

## Conclusion

Without involvement from the entire team, quality patient care simply is not possible. Multiple teams and team members need to come together to solve complex patient problems, conduct rounds, and respond to patient emergencies. Without Peter Pronovost listening to and involving nursing staff in solving patient care problems, for example, checklist use to improve patient care would not have been developed [28]. We advocate engaging medical students, residents, and medical facility staff alike for problem solving and listening to what other team members have to say. Other tools and interventions for addressing teamwork problems in medical teams include morbidity and mortality conferences [29], interpersonal and problem-solving team-building exercises [30], interprofessional education [31], and team training [32]. Overall, building the team in these ways can lead to greater team satisfaction, flattened hierarchies, and improved communication among team members [30].

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Ashley M. Hughes is a PhD student in the Applied Experimental Human Factors psychology program at the University of Central Florida in Orlando, where she received her bachelor's in psychology in 2010. She conducts research in the Institute for Simulation and Training, and her main interests are team training, simulation-based training, and teamwork, primarily in medical settings.

Eduardo Salas, PhD, is trustee chair, a professor of psychology, and director of the Human-Systems Integration Research Department in the Institute for Simulation and Training at the University of Central Florida in Orlando. Previously, he was director of UCF's Applied Experimental and Human Factors psychology PhD program and was head of the Training Technology Development Branch of the Naval Air Warfare Center Training Systems Division of the United States Navy.

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# Virtual Mentor

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## MEDICINE AND SOCIETY

### Leadership and Team-Based Care

John H. Armstrong, MD

Do effective endeavors require hierarchy, a chain of command with relationships defined by subordination? Rather than hierarchy, I suggest that what groups really need to be effective is clear structure: defined relationships (leadership and goals), set standards, shared respect, and a means for managing conflict.

Hierarchy is one form of structure, and the team is another. They often coexist, with expression depending on circumstances. In high-risk environments—those marked by sensory overload, an intense climate, time urgency, and distractions—a collaborative team model is more effective. Examples include the airplane cockpit, trauma bay, and combat.

Hierarchy connotes different levels of skill and importance among personnel; team members are considered equally competent and key to success. In a hierarchy, reporting relationships are vertical, as on an organizational chart; team relationships are represented horizontally on a position diagram like a playbook. Hierarchical reporting and decision making must be observed inflexibly; teams are more adaptable. In endeavors such as clinical care that involve many professionals from various disciplines, hierarchy can generate mistrust and resentment when status is a barrier to communication, while team organization makes better use of talent from all team members and promotes mission focus.

So what is a team? A team is a group of people committed to achieving a shared goal (i.e., a mission) together through interdependent actions and accountability to each other. Too often, the word “team” is used wishfully to describe mere groups of people who are not really collaborating [1]. In sports, for example, what distinguishes a Super Bowl champion team from a high-priced group of football players? Three elements come together: a collective goal that trumps discordant individual desires; collective practice that synchronizes actions; and collective performance that is measured and evaluated.

There is another aspect to team accountability: it keeps the team together. Well-functioning teams do not disintegrate under pressure; rather, team members are motivated by responsibility to each other. Team members do not act independently; they recognize that they work in the context of those around them and are interdependent. In teams, individual performance multiplies to a collective outcome greater than the sum of those performances [1].

Team structure serves as the foundation upon which essential processes for mission accomplishment—planning, communication, execution, and performance improvement—can occur. *Planning* is developing a mental model shared among team members that guides actions and includes common language, synchronization, and expectations for team members. With rehearsals, planning becomes readiness. *Communication* creates situational awareness through closed-loop messaging (speak, listen, and confirm), assertiveness (i.e., speaking up politely to be heard), and checklists, hand-offs, briefings, and huddles. *Execution* entails team members monitoring performance together, providing each other with back-up to prevent errors, and undertaking workload management, which requires vigilant adaptability when workload is low and prioritization when workload is high. *Improvement* results from timely feedback and debriefing to learn lessons. This latter point bears emphasizing: too often, we “identify” lessons rather than learning them. Lessons are learned when they result in team process changes. Improvement promotes accountability through measurable outcomes and processes [2].

### **The Leader’s Role**

Hierarchies and teams get direction from their leaders. Leadership style has a profound effect on organizational climate, which can enhance or reduce individual motivation. Different structures and circumstances may promote or require different leadership styles.

There are six general styles of leadership: directive, visionary, affiliative, participative, pacesetter, and coaching [3]. *Directive*, as the name suggests, is based on orders and consequences for failure. *Visionary* puts mission into context and communicates why one course of action is better for achieving shared goals. *Affiliative* is empathic, focuses on listening, and aims to meet the emotional needs of individuals in the organization. *Participative* is collaborative and builds consensus. It is inclusive in decision making, though not necessarily democratic. *Pacesetter* is marked by personal heroics that define standards and set the example, yet can be overachieving. Finally, *coaching* promotes long-term professional growth [3].

Again, there is no single leadership style that works for every situation: different structures will emphasize different leadership strategies. In my experience, leaders in hierarchical structures tend more toward directive, pacesetter, or visionary leadership approaches, while team organizations rely on a combination of coaching, participative, and affiliative styles.

The overall leader of a team inspires the group to achieve the mission, while supporting its members, and takes responsibility for the team’s success or failure. Yet each member within the team may take the lead on a particular task needed to accomplish a goal.

## Teamwork in Health Care

Until the current focus on reform [4], health care has been delivered as a loose affiliation of health professionals in various independent settings, leading to fragmentation as patients move through episodes of care. Hierarchy has dominated interprofessional relationships. As a complex adaptive system, though, health care delivery works optimally when it is collaborative [4]. In patient care, teamwork has two goals: improving patient outcomes by delivering quality care (defined by the Institute of Medicine as safe, timely, effective, efficient, equitable, and patient-centered [4]) and fostering team well-being through ensuring respectful interactions among all team members. In health care, the second goal is commonly forgotten. If team cohesiveness is not maintained, then missions do not get accomplished successfully over time.

An environment that supports teamwork cultivates professionalism, which keeps the focus on the most important person in health care, the patient [5]. When health professionals work collaboratively, scope of practice becomes more about defining roles and responsibilities among team members than about maintaining separate territories. Health professionals and patients exist in a health care ecosystem marked by interdependence and mutual accountability, whether we recognize it or not. The time has come to think of caring for the patient as a “team sport.”

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John H. Armstrong, MD, is state surgeon general and secretary of the Florida Department of Health and an affiliate associate professor of surgery at the University of South Florida Health Morsani College of Medicine in Tampa. Previously, he was the chief medical officer of the USF Health Center for Advanced Medical Learning and Simulation and director of the United States Army Trauma Training Center in Miami, where he led the development of a 2-week team training program for combat surgical teams.



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# Virtual Mentor

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## IMAGES OF HEALING AND LEARNING

### Medical Hierarchy and Medical Garb

Daniella M. Schocken, Aliye Runyan, MD, Anna Willieme, MFS, and  
Jason Wilson, MD

Although health care practitioners rely upon all of their senses—give or take taste, perhaps—to engage with patients and gather information, sight holds a special place above the rest. Medicine is a highly visual field. Caregivers at all levels and scopes of practice rely upon their sight to perform their work, not only to observe patients and render care, but also to engage with technologies and colleagues. Because of the growth of clinics and hospitals from individual and small-group practices to large networks with legions of providers, it has become more likely for doctors, nurses, and other members of care teams not to recognize one another in their working environments. Thus, many hospitals and other care systems institute uniforms to help visually distinguish employees. The color of a person's scrubs, for example, might indicate a nurse or an imaging technician.

Such distinctions are not entirely recent inventions. Physicians have been distinguished by their long white lab coats since the nineteenth century, when such attire was adopted by the medical profession in keeping with the paradigm of the physician-as-scientist. It is no accident that the ceremony that most often serves to mark the beginning of medical training is referred to by many institutions as the “white coat ceremony,” during which students receive their first lab coats. These coats are cropped to the waist; students do not receive the longer lab coats worn by physicians until they earn their medical degrees.

Patients, for their part, have their own responses to medical garb. In fact, some instances of hypertension during office visits that are not reproduced by at-home measurements are chalked up to “white coat syndrome”—a visceral response to the presence of clinical practitioners that is quantifiable in vital signs and often brought on by anxiety. Even so, many patients still enter clinics and hospitals with the expectation that they will see a doctor in a lab coat. Today, many nurse practitioners and physician assistants choose to wear a long white coat while seeing patients as well. Few patients recognize that other caregivers might wear such coats, or that doctors might eschew them.

Without medical garb specific to role and position, the burden falls on individual practitioners to introduce themselves clearly to their patients and ensure that their place in the care team is understood. Patients' right to know who is rendering their care and treatment stems naturally from their right to self-determination, much like

their right to informed consent. Ensuring that patients understand these caregivers' scope of practice further honors that right.

Likewise, clinicians should be made aware of their colleagues' roles in patient care. In care settings where medical garb is not differentiated, communicating this information may present challenges to the expediency and efficiency of action, particularly when critical or urgent care is being administered. However, visual distinctions between health care professionals have their own drawbacks, insofar as reinforcing the differences between team members can easily reinforce overly rigid role divisions and hierarchical inequities that undermine true teamwork.

A tension has developed between the garment's role as a sign of status and profession and its use in denoting the separation between physicians and their patients and among different health professionals. In figure A, a scene from a nineteenth-century operating theater establishes contrasts between the garments of the doctor, nurse, student, and patient. Students and observers sit in darkness, clad in black. Light is cast over the main event, the operation on the patient, whose breast is exposed for the surgery, conveying the vulnerability of her condition. The professor stands aside, garbed in white along with his surgical assistants, directing the proceedings. The nurse is distinct in her bonnet and apron, wearing both white and black. In addition to the statement this image makes about the historically gendered place of nurses in medicine, the nurse's clothing in this painting uniquely situates her in a liminal space, possessing the visual cues of both the learned and the learners. Roles are clearly defined and represented here, and a classical hierarchy is established in this scene.



Figure A.  
Thomas C. Eakins (1844-1916)  
*The Agnew Clinic, Portrait of David Hayes Agnew*  
1889

Oil on canvas, 74 1/2 x 130 1/2 inches

The University of Pennsylvania School of Medicine, Philadelphia, PA

Figure B shows a nurse tending to the wounds of soldiers in an English military hospital. This portrait feels far more intimate, an expression of the closeness between nurse and patient. Once again, the nurse is wearing the bonnet and apron as she carefully bandages the young man's arm. In this painting, physicians are not visible, but another type of uniformed caregiver is: the priest at the left hand side of the painting. The entire mood of the work is informal—no bedside rounds, patients walking along the hallway, a family member reading the paper—and makes a statement on the role of the nurse as a comforting presence more than an imposing figure, closer to patients than to physicians in the hierarchical structure.



Figure B.  
Sir John Lavery (1856-1941)  
*The First Wounded*  
1914-19  
litho  
Dundee Art Gallery and Museum

Figure C presents a more formally composed, haunting style and atmosphere when compared with the warmth of the previous image. It appears that the condition of the patient in this painting is more serious. Once again, the doctors in white are presiding over the scene while the nurses, in blue dress, are actually touching the patient, in both the fore- and background. Nurses' and physicians' garb is starkly differentiated and immediately identifiable, while their roles within the context of the work seem to be delineated such that doctors ruminate over care that nurses subsequently deliver. The closeness of nurses to the patients in all three of these images helps to illustrate how caregivers may be subject to hierarchical inequity in their professional relations.



Figure C.  
Hilding Linnqvist  
*Hospital Ward II*  
1920  
Moderna Museet, Stockholm  
Photograph © Moderna Museet, Stockholm

The resolution of this tension between the utility of medical garb and its potential consequences for workplace dynamics lies not in the reduction of visual distinctions between caregiver roles, but rather in the establishment of better interprofessional understanding and respect through new forms of training and educational interventions. The World Health Organization has advocated for improved

interprofessional teamwork in health care since 1978, and multiple reports have been issued since that time to reaffirm the importance of interprofessionalism with evidence of its efficacy for patient benefit [1-3]. A review of the literature indicates that the delivery of patient care improves among those who complete interprofessional training [4], most likely because of the impact of subtle prejudices and preconceptions on teamwork and collaboration among professionals who have not had such training [5]. Although students' professional identities may be well established before training in a medical profession even begins [3], educational interventions demonstrably reduce the formation of negative stereotypes between student groups [6].

The Liaison Committee on Medical Education has recommended for more than a decade that medical students receive training in professional communication [7], but recent analysis of curricula prepared for accreditation indicates that change has been slow with respect to the adoption of interprofessional training methods with measures of student performance [8]. Until more students are encouraged to build effective strategies for teamwork and communication across disciplinary divides, the sense will remain that elements of the care setting like medical garb that differentiates between practitioners reinforces inequitable hierarchies rather than facilitating collaboration.

By allowing care providers to readily recognize one another in the clinical setting, visual codes of medical garb solve more problems than they generate. If medical garb currently reinforces a hierarchical barrier in the clinic, then it is a failure of interprofessional training in collaborative medical practice, not an indictment of the utility of role differentiation. Effective teamwork relies as much upon a foundation of understanding team members' roles as it does on mutual respect and open communication.

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Daniella M. Schocken works in the Center for Advanced Clinical Learning and Simulation at the University of South Florida Health Morsani College of Medicine in Tampa. She graduated with distinction from Duke University with a bachelor of arts degree in cultural anthropology. Her interests include medical education and medical anthropology.

Aliye Runyan, MD, is the education and research fellow for the American Medical Student Association (AMSA) and the founder and former director of the AMSA Medical Humanities Scholars Program. While she was a student at the University of Miami-Miller School of Medicine, she worked on the establishment of the Ethics and Humanities Pathway at the University of Miami. Her research interests include ethics, medical humanities, and international and public health, especially women's health.

Anna Willieme, MFS, is the creator and director of ArtMed inSight, which uses art to enhance the visual diagnostic and communication skills of physicians, medical students, and health care practitioners and collaborates with leading teaching hospitals and medical schools.

Jason Wilson, MD, is an assistant professor of medicine in the Division of Emergency Medicine and the research director for the emergency medicine residency program at the University of South Florida Health Morsani College of Medicine in Tampa, where he completed his undergraduate medical and residency training. Dr. Wilson has a master's degree in anthropology from the University of Michigan. His research interests are in the social determinants of the emergency department patient population and the efficacy of outcome and flow metrics.

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# Virtual Mentor

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## OP-ED

### One Leadership Style Does Not Fit All

Catherine M. Lynch, MD

James MacGregor Burns described leaders as either transformational or transactional in style [1]. Transformational leaders mentor and empower their followers to reach their full potential. They provide goals, constantly work to improve and innovate; and encourage their followers to contribute more to their organization. In contrast, transactional leaders appeal to their subordinates' self-interests through a process of give and take. They establish roles, reward when expectations are met, and reprimand when they are not. In modern organizations, leadership research has shown that the transformational style, coupled with components of positive rewards and incentives, results in the more effective leadership [2].

Can we predict which leaders will be more likely to employ the transformational style? A meta-analysis of 45 studies on these leadership types found that female leaders were likely to be more transformational than male leaders [3]. Men tended to be more transactional when it came to disciplinary actions, while women tended to be so in rewarding behavior. (The researchers also found a third style, more prevalent in men than women, termed *laissez-faire*: a non-leadership style with little interest in management.)

So, in theory, women may be better equipped to be good leaders, including in medicine. This does not necessarily mean they are in leadership positions: women account for 37 percent of faculty in U.S. medical schools, but less than half as many women as men in academic medicine reach the rank of professor; for full professors, it is only one-fourth as many [4]. If women are natural leaders, why aren't more of them in leadership positions? One cause may be social perceptions of gender roles. Women leaders are also often faced with a "damned if you do, damned if you don't" proposition. The Catalyst organization described the issue as one of competing social expectations. Women are expected to be compassionate and nurturing; traits psychologists would describe as communally oriented. Agentic traits (i.e., those associated with self-regulating, proactive agency) such as aggression, decisiveness, ambition, and individualism are seen as more male traits that, when utilized by women, are often viewed as harsh or self-centered [5].

Furthermore, though the communal traits of compassion, sensitivity, and concern for others are certainly behaviors sought in medical care, these attributes are not the exclusive domain of women. In reality, most successful leaders employ a combination of both transformational and transactional leadership strategies [2].



As we look into the future needs of health care, what type of leaders are best equipped to direct patient-centered medical homes? Perhaps we should look into what exactly the medical home entails. As originally defined, the medical home is a team-based health care delivery system led by a physician, physician assistant (PA), or nurse practitioner (NP) that provides continuous and comprehensive medical care to patients with the goal of maximizing positive health outcomes [6]. One of the most indispensable elements of the medical home concept is appropriate care coordination, a cooperative effort between the patient, the family, the clinicians, the informational technologies, and the clinicians' staff. In the patient-centered medical home, the patient-doctor relationship may be best served by relational approaches that vary depending on the circumstances and the patient's style rather than by a single paradigm. Patients need to be able to find clinicians who suit their needs and expectations, and all should be searching for someone they feel best cares for them. For some patients, that person will be decisive and assertive; for others, that person will be communally oriented and, perhaps, solicit more patient input. So is it appropriate to consider the notion that better care would be provided by cutting the diversity of the caregivers in half?

The quintessential physician in our grandparents' era, Marcus Welby, MD, practiced medicine in a world when expectations and standards might best be described by the old adage "to comfort always, relieve suffering often, and cure rarely." Today, however, it seems that medicine is focused on curing always, relieving suffering if we have time, and comforting rarely. The idea of the patient-centered medical home is to add comfort and compassion back into the patient care equation; and this will not be best accomplished by forcing everyone involved to conform to one model of clinician-patient relationship.

But we physicians have for years resisted standardization of practices because patients are diverse and their care often requires a variety of options. Twenty-first century medicine will be best served not by clinicians of a particular gender or demographic but by clinicians who are focused on the principles of the Hippocratic Oath that we swear.

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Catherine M. Lynch, MD, is the associate vice president for women's health, associate dean for faculty development, and a professor of obstetrics and gynecology at the University of South Florida Health Morsani College of Medicine in Tampa.

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### Suggested Readings and Resources

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# Virtual Mentor

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## About the Contributors

### Theme Issue Editor

Jennifer Chevinsky is a third-year medical student on rotations at the Lehigh Valley Health Network in Allentown, Pennsylvania, through the University of South Florida Health Morsani College of Medicine SELECT Program. She is the student director for the American Society for Bioethics and Humanities and a member of the American Medical Association medical student section's Committee on Bioethics and Humanities. She has a degree with honors in bioethics in cross-cultural perspectives from the University of Connecticut's combined program in medicine. Jennifer's interests include international perspectives on bioethics, Jewish medical ethics, genethics, and values-based practice in medical education.

### Contributors

John H. Armstrong, MD, is state surgeon general and secretary of the Florida Department of Health and an affiliate associate professor of surgery at the University of South Florida Health Morsani College of Medicine in Tampa. Previously, he was the chief medical officer of the USF Health Center for Advanced Medical Learning and Simulation and director of the United States Army Trauma Training Center in Miami, where he led the development of a 2-week team training program for combat surgical teams.

Erin L. Bakanas, MD, is an associate professor of internal medicine and associate director of the Bander Center for Medical Business Ethics at Saint Louis University School of Medicine in Missouri. She teaches medical ethics to medical students and residents and serves as chair of the Saint Louis University Hospital ethics committee. She works in a general internal medicine practice where she enjoys collaborating with two advanced practice registered nurses.

Valarie Blake, JD, MA, is a senior research associate for the American Medical Association Council on Ethical and Judicial Affairs in Chicago. Ms. Blake completed the Cleveland Fellowship in Advanced Bioethics, received her law degree with a certificate in health law and concentrations in bioethics and global health from the University of Pittsburgh School of Law, and obtained a master's degree in bioethics from Case Western Reserve University. Her research focuses on ethical and legal issues in assisted reproductive technology and reproductive tissue transplants, as well as regulatory issues in research ethics.

William Bond, MD, MS, is the designated institutional official, chair of the graduate medical education committee, and medical director for educational technology in the Division of Education, all at Lehigh Valley Health Network in Allentown,

Pennsylvania. He is also a professor of medicine on the Clinical Educator Pathway at the University of South Florida Health Morsani College of Medicine in Tampa and a practicing emergency physician. He is interested in the use of simulation in improving patient safety and reducing cognitive error.

Allesa English, MD, PharmD, is the director of the SELECT Program preclinical curriculum and the director of the MD advising program at the University of South Florida Health Morsani College of Medicine in Tampa.

Ashley M. Hughes is a PhD student in the Applied Experimental Human Factors psychology program at the University of Central Florida in Orlando, where she received her bachelor's in psychology in 2010. She conducts research in the Institute for Simulation and Training, and her main interests are team training, simulation-based training, and teamwork, primarily in medical settings.

Catherine M. Lynch, MD, is the associate vice president for women's health, associate dean for faculty development, and a professor of obstetrics and gynecology at the University of South Florida Health Morsani College of Medicine in Tampa.

Alicia D.H. Monroe, MD, is a professor of family medicine, chief academic officer, and vice dean of educational affairs at the University of South Florida Health Morsani College of Medicine in Tampa.

Primi Ranola is a master's degree candidate in Northwestern University's program in medical humanities and bioethics. She is a graduate of the University of Rochester and an intern for the American Medical Association Council on Ethical and Judicial Affairs in Chicago.

Aliye Runyan, MD, is the education and research fellow for the American Medical Student Association (AMSA) and the founder and former director of the AMSA Medical Humanities Scholars Program. While she was a student at the University of Miami-Miller School of Medicine, she worked on the establishment of the Ethics and Humanities Pathway at the University of Miami. Her research interests include ethics, medical humanities, and international and public health, especially women's health.

Eduardo Salas, PhD, is trustee chair, a professor of psychology, and director of the Human-Systems Integration Research Department in the Institute for Simulation and Training at the University of Central Florida in Orlando. Previously, he was director of UCF's Applied Experimental and Human Factors psychology PhD program and was head of the Training Technology Development Branch of the Naval Air Warfare Center Training Systems Division of the United States Navy.

Daniella M. Schocken works in the Center for Advanced Clinical Learning and Simulation at the University of South Florida Health Morsani College of Medicine in Tampa. She graduated with distinction from Duke University with a bachelor of arts

degree in cultural anthropology. Her interests include medical education and medical anthropology.

Dawn M. Schocken, MPH, is director of the Center for Advanced Clinical Learning at University of South Florida Health Morsani College of Medicine. She chairs the Interprofessional Education Committee at USF Health and is interested in enhancing health professional students' education through simulation and experiential learning.

Amy H. Schwartz, PharmD, BCPS, is the associate dean for curriculum development at the University of South Florida Health College of Pharmacy. She is an active member of the USF Health Interprofessional Education Committee and is interested in evaluation of the students' learning.

Frazier T. Stevenson, MD, is the Associate dean for undergraduate medical education at USF Health Morsani College of Medicine. He is interested in Interprofessional Education and currently is funded by the Arthur Vining Davis Foundation to study the effects of interprofessional education in pre-clinical learners.

Robert M. Walker, MD, is an associate professor of medicine and the director of the Division of Ethics, Humanities, and Palliative Medicine at the University of South Florida Health Morsani College of Medicine in Tampa.

Anna Willieme, MFS, is the creator and director of ArtMed inSight, which uses art to enhance the visual diagnostic and communication skills of physicians, medical students, and health care practitioners and collaborates with leading teaching hospitals and medical schools.

Jason Wilson, MD, is an assistant professor of medicine in the Division of Emergency Medicine and the research director for the emergency medicine residency program at the University of South Florida Health Morsani College of Medicine in Tampa, where he completed his undergraduate medical and residency training. Dr. Wilson has a master's degree in anthropology from the University of Michigan. His research interests are in the social determinants of the emergency department patient population and the efficacy of outcome and flow metrics.

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