Taking One for the Team

The teams of my medical student and resident days in the 1990s were haphazard packs of students, interns, residents, and attending physicians. Despite the rigid hierarchy, our roles were poorly defined. The royal “we” practically ensured that a patient’s request for a glass of water would go unfulfilled; there was no plan for managing questions that did not fit our paradigm. We had no training in how to communicate with nonphysician “them” other than being told it was in our best interest to play nice. Few of us had any clue about our training or roles.

Fast-forward to the present. For the past 4 years, I’ve been part of a Veterans Affairs home-based, primary care multidisciplinary team, along with registered nurses, nurse practitioners (NPs), a psychiatrist, physical therapists, registered dietitians, pharmacists, social workers, and administrative staff. We confer frequently. Our weekly meeting is a lively review of shared patients. When a complicated question arises about how best to manage, say, an elderly patient with dementia while keeping him at home, the people whose expertise we require are in the room. Like any good team, we are greater than the sum of our parts.

In this issue, the American College of Physicians (ACP) presents its strong support for dynamic multidisciplinary clinical care teams as the best model for U.S. health care (1). For institutions and practices with effective teams in place, the position paper provides support; for others, it provides motivation. The College offers 8 principles applicable across settings and urges teams to take advantage of the range of members’ experience and abilities, while focusing on patient needs. The College also addresses broader issues, including calling for research on liability in team-based care, proposing that future outcome studies examine teams rather than individuals and suggesting that state legislatures review licensure laws.

Recently, many organizations have published position papers on multidisciplinary clinical care teams (2–4). Many tenets are similar: the benefits of a team-based culture, the obligation of professionalism, understanding the skills and training of fellow team members, assigning responsibilities on the basis of abilities and team needs, the shared goal of providing the best medical care to the patient, and so on.

Yet there remains overwhelming lack of consensus regarding NP scope of practice and team leadership. The American Academy of Family Physicians endorses “a quality, physician-led team for every patient”; the American Academy of Pediatrics calls for “a team-based approach led by a pediatrician”; and the American College of Physicians recommends “access to a personal physician who is trained in the care of the ‘whole person’ and has leadership responsibilities for a team of health professionals” (1–3). According to the American Association of Nurse Practitioners, the health care team “does not belong to a single provider, system or health care discipline” (4).

Some of the content in the ACP position paper will not inspire high-fives from our NP colleagues. The otherwise useful definition of the numerous activities that comprise primary care, for example, asserts that NPs should generally not be managing problems beyond a “well-defined single problem with standardized treatment algorithms.” Although the position paper references several Institute of Medicine reports, it neglects to mention the oft-quoted and evidence-based Institute of Medicine consensus report on the future of nursing, which calls for NPs to practice to the full extent of their education and training and advises that they achieve higher levels of education to meet increasing demands (5). Although solving the scope of practice controversy may be beyond the reach of the College’s position paper—or of this editorial—failure to resolve the issue hinders the development of dynamic clinical care teams, particularly in states where NPs can practice autonomously.

It is heartening, then, to find the College rising above the familiar negative rhetoric by acknowledging the effectiveness of NPs in some settings, such as nurse-managed health centers in underserved areas. The suggestion for creating “virtual” clinical care teams that can collaborate electronically or telephonically is wise. Similarly, the College expresses its willingness to consider others in leadership roles, recognizes that effective teams may have a “nuanced” approach to defining leadership that may not follow the usual hierarchy, and comments that these conflicts are more often a problem in theory rather than practice (6).

Two of the College’s most fundamental principles center on a mutual comprehension of individual roles. First, such a “deep understanding of... how discipline-specific roles and responsibilities can be maximized” can only happen if team members have a solid sense of colleagues’ skills. The position paper includes a detailed sketch of the internist’s roles and abilities but no reciprocal definition for those of other health care professionals. Describing what NPs and physician assistants do simply as “complementary and unique approaches, as well as additional skills in the service of patients and families” misses an opportunity to characterize those approaches. Nursing theory, for example, a bedrock of nursing education, encompasses the patient, environment, health, prevention, and advocacy. The more we understand our fellow team members’ education, capabilities, and philosophies, the more artfully we can match team members with patient needs.

Second, the College points to the essential task of training our students and residents in team-based care. The earlier and more relentlessly we model interprofessional relationships that demonstrate respect, good communica-
tion, and collaboration, the better. We should also play close attention to field reports from novel interdisciplinary programs that involve integrating students and residents into teams, such as the Accreditation Council for Graduate Medical Education Educational Innovations Project, the Veterans Affairs Centers of Excellence in Primary Care Education (www.va.gov/oaa/rtfcoe.asp), and Macy Foundation interprofessional education grantees’ research and conference proceedings (7, 8). Leadership training in interdisciplinary team settings also deserves a place in the curriculum. Physicians are not necessarily natural-born leaders.

The College’s position paper adds an important voice to the conversation about team-based care by calling for health care providers to appreciate the skills and training of team members. Whether it’s possible to create a document on team-based care that will have widespread interprofessional appeal remains unclear. We may never reach a national consensus on NP scope of practice. Yet future efforts should build on this energy, engaging representatives from diverse health professions to iteratively refine the structure, roles, and assessment strategies for care teams. It behooves all of us to strive for the success of team-based care for the benefit of our patients and ourselves.

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Acknowledgment: The author thanks Cary Gross, MD, for his helpful comments.

Potential Conflicts of Interest: None disclosed. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M13-2105.

References