AMA *Code of Medical Ethics*

10.8 Collaborative Care

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

  (i) understanding the range of their own and other team members' skills and expertise and roles in the patient's care;

  (ii) clearly articulating individual responsibilities and accountability;

  (iii) encouraging insights from other members and being open to adopting them;

  (iv) mastering broad teamwork skills.

(b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, respecting the unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role

As leaders within health care institutions, physicians individually and collectively should:

(g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(i) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel.

AAMA Principles of Medical Ethics II,V,VIII

Background report(s):

CEJA Report 1-I-06 Collaborative care
CEJA Report 2-I-22 Amendment to Opinion 10.8, "Collaborative Care"

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 02-I-22

Subject: Amendment to Opinion 10.8, "Collaborative Care"

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician assistants, midwives) as a growing share of health care providers in the United States. Moreover, nonphysician practitioners have gained increasing autonomy, authorized by state governments (e.g., legislatures and licensing boards) in response to the lobbying from professional associations, as part of an effort to ameliorate provider shortages, and in response to rising health care costs. Expanded autonomy has increased the interactions of independent nonphysician practitioners and physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced training that results in a doctorate degree, such as "Doctor of Nursing." Such terminology sometimes results in misconception or confusion for both patients and physicians about the practitioner's skillset, training, and experience.

The following is an analysis of the ethical concerns centering on issues of transparency and misconception. In recognition of the growing relevance of the issue, the Council brings this analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion 10.8 Collaborative Care.

DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

The term "nonphysician practitioners" denotes a broad range of professionals including nurse practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There are "multiple pathways" for one to become a nonphysician practitioner, the most common is a nurse earning a "master's degree or doctoral degree in nursing" after initial completion of a bachelor's degree [1]. However, the skill sets and experience of nonphysician practitioners are not the same as those of physicians. Hence, when a nonphysician practitioner identifies themself as "Doctor" consistent with the degree they received, it may create confusion and be misleading to patients and other practitioners.

PATIENT CONFUSION AND MISCONCEPTION

Patient confusion and misconception about provider credentials is a significant concern. Data suggest that many patients are not sure who is and who is not a physician. For example, 47% of respondents in one survey indicated they believed optometrists were physicians (10% were unsure), while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

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of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although 74% identified them as nonphysicians.

Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4], Al-Agba and Bernard note how in "recent years, an explosion of doctorates in various medical professions has made the label of 'doctor' far less clear", a common example being that of the of the "Doctor of Nursing Practice" (DNP) [3]. The DNP, a professional practice doctorate (distinct from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about providing better patient care, but is rather a "political maneuver, designed to appropriate the title of 'doctor' and create a false sense of equivalence between nurse practitioners and physicians in the minds of the public" [3].

The problem of identification has been recognized by some states where NPs with a doctorate are only allowed to be "addressed as 'doctor' if the DNP clarifies that he or she is actually an NP" and some jurisdictions require NPs without a doctorate to have special identification that "unambiguously identifies them" [5]. From an ethical standpoint, NPs have a duty as do all health care practitioners, including physicians, to be forthright with patients about their skill sets, education, or training, and to not allow any situation where a misconception is possible. Ambiguous representation of credentials is unethical, because it interferes with the patient's autonomy, as the patient is not able to execute valid informed consent if they misconstrue the provider. For example, a patient may only want a certain procedure done by a physician and then assent to an NP performing the procedure, under the mistaken belief that the NP is a physician. However, such an assent to the medical procedure is neither a valid *consent* nor an adequately informed *assent*, as the patient's decision is founded on a flawed basis of key information, i.e., the nature and extent of the practitioner's skill set, education, and experience.

GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of transparency of credentials and professional identification. However, the *Code* could be modestly amended to offer specific guidance regarding transparency in the context of team-based care involving nonphysician practitioners.

House Policy

H-405.992 – "Doctor as Title," states:

> The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title ""Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

D-405.991 – "Clarification of the Title "Doctor" in the Hospital Environment," states:

> Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

H-405.969 – "Definition of a Physician", states:

> … a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
>
> AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "nonphysician" and define the nature of their doctorate degree.

Code of Medical Ethics

The Code already addresses transparency in context of residents and fellows. Opinion 9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care," possesses some language regarding transparency and identification where it states:

> When they are involved in patient care, residents and fellows should:
>
> (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care.

In the context of a team-based collaborative care involving nonphysician practitioners, Opinion 10.8, "Collaborative Care" is the most relevant *Code* opinion. It gives guidance on the collaborative team-based setting, where a mix of health professionals provide care. However, Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care. Hence, amendment to Opinion 10.8 is warranted.

RECCOMENDATION

In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion 10.8, "Collaborative Care," be amended as follows and the remainder of this report be filed:

> In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician relationship,~~ sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.
>
> Health care teams often include members of multiple health professions, including physicians, nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers among others. To foster the trust essential to healing relationships between patients and physicians or nonphysician practitioners, all members of the team should be candid about their professional credentials, their experience, and the role they will play in the patient's care.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As clinical leaders within health care teams, physicians individually should:

(a) Model ethical leadership by:

(i) Understanding the range of their own and other team members' skills and expertise and roles in the patient's care
(ii) Clearly articulating individual responsibilities and accountability
(iii) Encouraging insights from other members and being open to adopting them and
(iv) Mastering broad teamwork skills

(b) Promote core team values of honesty, discipline, creativity, humility and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member's opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family, ~~and~~ respecting the~~ir~~ unique relationship of patient and family as members of the team.

(f) Assure that all team members are describing their profession and role.

As leaders within health care institutions, physicians individually and collectively should:

(~~f~~g) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(~~g~~h) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(~~hi~~) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(j) Promote a culture of respect, collegiality and transparency among all health care personnel.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

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REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-I-16)
Collaborative Care
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Traditionally, the practice of medicine was conceived as a single physician providing care directly to an individual patient. But as health care focuses increasingly on quality, efficiency, and the experiences and outcomes of the patient, services are no longer necessarily provided by a single physician. Rather, a patient's care now often lies in the hands of many collaborating health care professionals.

Teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams physicians have a responsibility to model ethical leadership, promote core team values, support transparent decision making, encourage open discussion and shared accountability, and respect the patient's and family's unique relationship as team members. As leaders within health care institutions, physicians should advocate for the resources and support health care teams need to function effectively, encourage institutions to identify and address barriers to collaboration, and promote policies and procedures to constructively address conflicts that adversely affect patient care.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-16

Subject: Collaborative Care

Presented by: Ronald A. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (John P. Abenstein, MD, Chair)

Traditionally, the practice of medicine was conceived as a single physician providing care directly to an individual patient. But as health care focuses increasingly on quality, efficiency, and the experiences and outcomes of the patient, services are no longer necessarily provided by a single physician. Rather, a patient's care now often lies in the hands of many collaborating health care professionals. Teams may be formal structured units or ad hoc groups of physicians, nurses, social workers and other health professionals, at one or several sites of care, all of whom play various clinical and administrative roles in the care of a single patient.

Systemic changes in the nation's health care system are also driving the movement toward collaborative care as a tool for pursuing coordinated, patient-centered care [1]. Collaborative care has been tested and measured in clinical settings around the country and its importance has been translated into law and policy [2, 3]. A growing body of research indicates that collaborative care can enhance health care quality and outcomes for individual patients, may enhance access to care, and may help lower—or slow the rate of increase of—health care costs [4, 5, 6, 7]. Further, well-functioning teams that provide safe, efficient, high-quality care can reduce burnout and improve morale among health care personnel [8].

This report examines key ethical considerations for health care teams engaged in providing care collaboratively and develops guidance for physicians as leader-members of care teams.

ETHICAL PRINCIPLES FOR COLLABORATIVE CARE

A well-functioning team capable of optimizing patient outcomes is defined by dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

Patient-Centered Care

Collaborative care is first and foremost patient-centered care. The physician's duty to hold the patient's interests paramount (Principle VIII) does not diminish when care is provided by professionals working as a team. Like individual health care professionals, teams must ensure that the care they deliver aligns with the values and needs of the patient [9]. Teams must support

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patients as decision makers (and families where appropriate) and afford them opportunities to participate actively in treatment as members of the team. Patients and their families should feel they are understood and respected by the health professionals who provide care. They must be able to ask questions and must be confident that all health care personnel will address any issues openly and honestly.

Protecting the Patient-Physician Relationship

The patient-physician relationship remains central in collaborative care environments, just as in any other health care setting [9]. Physicians remain advocates for their patients and are responsible for putting the patient's welfare above obligations to others [10]. The relationship that the team as a whole has with the patient should be supportive of the interaction between the patient and physician.

Mutual Respect and Trust

To provide efficient, effective care, all members of a health care team must contribute actively, which requires that members mutually respect and trust one another. Health care professionals must be confident that their colleagues are performing at their highest standard of practice, and that the team, overall, is providing optimal care. When members do not respect and trust one another, individual contributions can be misinterpreted or ignored, leading to tension or lapses in communication that can in turn compromise a patient's health and safety. Members of a well-functioning team will acknowledge and appreciate the contributions made by each and every team member [9]. Mutual respect and trust strengthen the clinical team and give all members an opportunity to serve as positive role models for one another and to inspire and motivate their colleagues [9]. Honoring the work of one's colleagues not only underscores the importance of individual contributions, but also emphasizes the contribution of the team as a cohesive unit [9].

Effective Communication

Effective communication is fundamental to providing safe, optimal care to patients [9]. Every member of the team shares the responsibility to communicate effectively, clearly, and consistently. Physicians can play a leading role by modeling effective communication strategies. When physicians provide clear, concise information or instructions to colleagues they demonstrate behaviors that others on the team can utilize to communicate efficiently and effectively themselves [9].

Accountability

Accountability is likewise a core ethical principle for collaborative care. Given the fiduciary nature of the patient-physician relationship as well as the expectations society places on physicians because of their knowledge and training, physicians are accountable for patient care and outcomes [9]. Nonetheless, all members of the team are accountable for their individual practice and each shares responsibility for the functioning of the team as a whole, while protecting patient well-being and ensuring that the team focuses on patient care as the common goal.

Beyond accountability to individual patients, physicians and health care teams also have a responsibility to the communities in which they work to be prudent stewards of community resources [11]. Physicians and teams have a responsibility to ensure that providing care collaboratively not only benefits individual patients, but also helps to achieve efficiency and value for the health care system to benefit the whole community.

KEY ATTRIBUTES OF EFFECTIVE TEAM MEMBERS

The attributes that individual members bring to a team are also important for effective team functioning. The Institute of Medicine, for example, suggests the following five key attributes: honesty, discipline, creativity, humility, and curiosity [1].

Within a successful team, members are honest and transparent about goals, decisions, mistakes, and fears [1], and engage in open dialogue that creates mutual trust [12].

A functional team also has disciplined members, with each performing assigned duties and sharing new information with other members to improve individual and team operations [1]. They fulfill responsibilities even when doing so is inconvenient or uncomfortable [1]. Such disciplined performance allows members not only to comply with established protocols, but to develop mutual respect and pursue improvement while doing so [1, 12].

Creativity is another important attribute that allows the team to work together effectively on complicated health issues. Creativity involves team members enthusiastically engaging new problems to find innovative solutions [1]. Further, creative teams do not view failed attempts and negative outcomes as the destruction of team goals, but as opportunities to learn [1].

With humility, team members recognize differences in training among the group, but do not view one form of training as wholly superior to all others [1]. Also, members understand that they are all humans susceptible to making mistakes [12]. These attitudes enable members to rely on one another, regardless of hierarchy [1], and to share constructive criticism to overcome professional and ethical obstacles.

Lastly, effective members of collaborative care teams exhibit curiosity and actively use knowledge gained from their daily lives toward the continuous improvement of individual and team efforts [1].

The composition of the team that delivers care—more or fewer physicians relative to other clinicians, mix of expertise, etc.— may vary in different contexts, such as chronic versus acute care or in-patient versus outpatient settings. For example, chronic illness is often managed most effectively by a team whose membership is stable. In contrast, acute care, especially in-patient care, is frequently provided by specialists who may work with different teams from day to day. Yet in every context, an identified individual needs to play a leadership role and take responsibility for collecting and synthesizing the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan for the patient [9]. In most contexts, a physician is best able to serve as team leader.

LEADERSHIP BEHAVIOR AND CONCEPTS

An effective team requires a clinical leader who takes responsibility “for maximizing the expertise and input of the entire team in order to provide the patient with comprehensive and definitive care” [9]. Clinical leaders ensure that the team as a whole functions well and facilitates decision-making [9], and is ultimately accountable to patients. Clinical leaders must use their training and experience to interpret and synthesize the information provided by team members to make a differential diagnosis and develop a plan of care. Effective clinical leaders foster common understanding about responsibilities and encourage open communication among patients, families, and the entire health care team.

Physicians are uniquely suited to serve as clinical leaders by virtue of their thorough and diverse training, experience, and knowledge [9]. Their distinctive appreciation of the breadth of health issues and treatment options in their field of practice also enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient. This expertise, as well as patient expectations—which hold as much in a setting of collaborative care as in a one-on-one office visit—make it most appropriate that a physician serve as a team's clinical leader although this does not necessarily mean that physicians will take the helm for every aspect of decision-making or coordinate every detail of treatment. Other health care personnel bring expertise and knowledge to the team and in many instances will be in charge when their expertise is most needed [9].

Although traditional notions of liability map poorly against the changes taking place in how, where, and by whom health care is delivered, physicians still can be held legally accountable for the actions of medical personnel working under their supervision [13]. To this extent, it currently makes sense from a legal perspective to have the physician serve as clinical leader. However, as health care continues to evolve and roles become increasingly fluid there is need for a more nuanced understanding of how teams and their members are mutually accountable to patients and to one another over the course of a patient's care, legally as well as ethically.

The role of clinical leader should be distinguished from that of clinical coordinator. While a physician should be the clinical leader of the health care team, the clinical coordinator of the team need not be. The clinical coordinator is the team member who, "based on his or her training, competencies and experience, is best able to coordinate the services provided by the team so that they are integrated to provide the best care for the patient" [9].

Transactional versus transformational leadership

The concepts of "transactional" versus "transformational" leadership offer a powerful framework for thinking about physician leadership in the context of collaborative care. Briefly, transactional leaders largely intervene in a "corrective" mode episodically when members deviate from a defined standard [14]. Transformational leaders, in contrast, are continuously engaged in relationships that inspire followers through charisma, clearly articulated visions, and ongoing personalized guidance [14, 15]. In a clinical context, for example, a transformational physician leader might hold informal five- to ten-minute "huddles," in addition to weekly team meetings, to keep the team on the same page [16].

Some evidence suggests that transformational leadership has positive effects on followers' task performance and perceptions of job characteristics and their leaders, and that such leadership behaviors can be taught [14, 15, 17, 18]. Leadership behavior influences how well a team functions. Clearly communicating a shared vision, connecting well to emotional needs, seeking consensus and collaboration, role-modeling, or coaching can each enhance the effectiveness of a team [19].

Responsibilities as Individuals, Team Members & Institutional Leaders

As clinical leaders in collaborative care, physicians have ethical responsibilities as individuals, as members of the team, and as leaders in their institutions [12].

As individuals, physicians have a responsibility to respect other team members, understand their own and other team members' range of skill and expertise and role in the patient's care, and master broad teamwork skills [12]. Like all team members, physicians should be open to adopting insights

from other members. They should communicate respectfully with other team members, even in the face of controversy, and should be welcoming to new members. Physicians can model ethical conduct for fellow team members—e.g., by avoiding intimidating body language or speaking disrespectfully about patients—and should encourage other team members to behave accordingly [20].

As clinical leaders in health care teams, physicians are in a position to foster the key attributes of effective team members and to promote respect among team members. They can and should help clarify expectations so that the team can establish systematic and transparent decision making. As leaders, physicians can likewise encourage open discussion of clinical and ethical concerns and help ensure that every member's opinion is heard and considered [21], and that team members share responsibility and accountability for decisions and outcomes [12].

Teams need support and resources to optimize patient-centered care [12]. Such resources might include additional training in teamwork skills, clerical support, flexibility in staff scheduling to promote continuity of team membership, or additional staff to provide skills not already represented among team members. Teams also need the organizations in which they provide care to recognize and respect the unique relationship between team and patient. Further, explicit recognition of effective teams by organizational leadership conveys the message that teamwork is valued and important to the organization. Finally, teams need their organizations to provide fair mechanisms for assessing the team's performance [12]. As leaders within their institutions, physicians should help ensure that teams are well supported and that their contributions to the quality and patients' experience of care are appropriately recognized.

CHALLENGES TO COLLABORATION

Teams can face a variety of challenges to effective collaboration, many of which are tied to the culture and structure of the health care institution within which they work. Of particular concern, teams may fall short of the goal of optimizing patient-centered care and outcomes when they lack resources, when institutional barriers inhibit effective team functioning, and when there is ongoing conflict within the team.

Inadequate Resources

While some individuals may naturally possess the necessary traits to work successfully in a team, many others do not. Physicians have ultimate responsibility and expect accountability within a team; development of team leadership skills will foster effective teamwork. Changes in how physicians and other health care personnel are taught to view teamwork, such as the use of RACI charts (which delineate who is Responsible, Accountable, Consulted, or Informed in the given context)[22], as well as specific training in teamwork skills can reduce conflict and improve team performance [23]. Ideally, interdisciplinary training begins early in medical education, a concept that has been embraced by the medical community [24]; the Accreditation Council for Graduate Medical Education identifies interpersonal and communication skills as a core competency. The ACGME notes that these skills "result in effective information exchange and teaming with . . . professional associates" [23]. Organizations may also find it useful to implement their own training for teamwork tailored to the culture of the institution. Such training can provide common structures, processes and expectations for health care professionals who work together on a regular basis.

Institutions also need to provide adequate administrative support for teams, promote scheduling practices that help ensure workload and duty hours are distributed fairly across personnel, and

sustain stable team membership to the extent possible. Teams function best when they have input into the structure and function of the institutions in which they practice.

Institutional Culture

The culture of an institution can also pose challenges for effective teamwork. In order to create a practice environment that encourages collaborative care, an organization's leaders must actively foster this new environment. Leaders must commit fully to change over the long term; adhering to new methods of communication and teamwork requires diligence and oversight, lest old patterns reemerge [25]. Organizations have the opportunity and responsibility to nurture supportive environments by helping teams develop shared goals and establish and maintain clear roles within the team. Leaders foster collaborative environments by being seen to value other health care professionals in addition to physicians; fostering mutual trust within teams; supporting effective communication and fair, objective measurement of processes focused on improving team function and outcomes [1].

Health care institutions share accountability both to individual patients and to their communities for ensuring high quality care, although other influences, including, prominently, the decisions and policies of third-party payers, also may be involved. Physicians can play an important role in holding institutions to this responsibility by advocating for the resources teams need to function effectively and by identifying aspects of institutional culture that create barriers to effective teamwork.

Fluctuating Team Membership

The complex nature of health care delivery means that a team's composition is not always constant [26]. For example, in emergency care scenarios, teams often are abruptly created to address a patient's imminent needs only to disband when the patient is transferred or discharged. An institution's rotation of health care personnel can also lead to new teams continuously being created, with each individual joining a new team during his or her next shift. Since trust and mutual respect between team members is often built over time, a constant fluctuation of membership can pose significant obstacles for effective team performance. Educating individual staff members on the principles of effective teamwork enables them to bring their understandings to each newly founded collaboration [1].

Conflict within Teams

Constructive debate is necessary for a group of individuals to come to a consensus on a complicated health decision [12]. Because each team member adds a distinct perspective to the team, conflict may arise when the team's decision is at odds with a member's training, experience, or personal beliefs and values, or when a member's behavior hampers team performance [9, 12]. A conflict resolution mechanism is needed when the degree of conflict interferes with team performance [12].

Without institutional means to address conflicts, teams risk demise when members are unable to voice their concerns and frustrations without fear of reprisal [12]. Conflicts that are not addressed or resolved, or not handled fairly, undermine the team and degrade any trust and mutual respect that has been built [25]. Because collaborative care has become essential to contemporary health care, conflict must be minimized to prevent the reduction of team functionality [1]. Institutions must establish standards for determining when conflict interferes with achieving the team's goals and must be addressed and what procedures should be used to resolve the situation [9, 12].

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

In health care, teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Such teams are defined by their dedication to providing patient-centered care, protecting the integrity of the patient-physician relationship, sharing mutual respect and trust, communicating effectively, sharing accountability and responsibility, and upholding common ethical values as team members.

An effective team requires the vision and direction of an effective leader. In medicine, this means having a clinical leader who will ensure that the team as a whole functions effectively and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

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(iv) mastering broad teamwork skills.

(b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and commitment to continuous improvement.

(c) Help clarify expectations to support systematic, transparent decision making.

(d) Encourage open discussion of ethical and clinical concerns and foster a team culture in which each member’s opinion is heard and considered and team members share accountability for decisions and outcomes.

(e) Communicate appropriately with the patient and family and respect their unique relationship as members of the team.

As leaders within health care institutions, physicians individually and collectively should:

(f) Advocate for the resources and support health care teams need to collaborate effectively in providing high-quality care for the patients they serve, including education about the principles of effective teamwork and training to build teamwork skills.

(g) Encourage their institutions to identify and constructively address barriers to effective collaboration.

(h) Promote the development and use of institutional policies and procedures, such as an institutional ethics committee or similar resource, to address constructively conflicts within teams that adversely affect patient care.

(New HOD policy)

Fiscal note: less than $500

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