Fumbling Toward the Future: Internal Medicine and Clinical Care Teams

It is widely agreed that the ills of primary care in the United States could be improved if not cured by an evolution away from “physician-centric” care models and toward team-based care. Clinical care teams promise improved access and quality at lower costs than the status quo. Team-based care has, however, been slow to develop. Obstacles include physician culture and reimbursement mechanisms.

The American College of Physicians (ACP) grapples mainly with the first of these formidable obstacles in its position paper on clinical care teams (1). Physicians, especially those in small practices, are notoriously resistant to surrendering clinical autonomy and to anything less than unambiguous authority over their clinical practices (2). Clinical care teams need not threaten such authority if physicians are charged with leading them, but there is widespread debate over proper lines of authority in such teams. The American Medical Association and American Academy of Family Physicians assert that only physicians should lead teams (3, 4). However, such accrediting organizations as the National Committee for Quality Assurance and Institute of Medicine suggest that nonphysician leadership is perfectly compatible with well-functioning, team-based care (5, 6). And the American Association of Nurse Practitioners has categorically opposed any attempt to restrict clinical care team leadership to physicians (7).

The ACP seeks to offer a nuanced position on team leadership issuing from the requirements of medical professionalism—that is, the necessary commitments of health professionals to patient welfare and the meeting of patient needs. According to the ACP, assignment of responsibilities within a team must be such as to assure that patients receive the care they need at any given time. From this promising beginning the question of team leadership is then fudged in what follows. Patients, we are told, deserve “access to a personal physician who . . . has leadership responsibilities for a team of health professionals.” But, on the other hand, “effective and dynamic teams have a ‘nuanced’ approach to defining team leadership” and such teams “recognize that leadership of a team in any particular task should be determined by the needs of the team and not by traditional hierarchy” (1, 6). The latter statements echo an Institute of Medicine discussion paper that explicitly disavows taking a position on who should lead clinical care teams (6). Readers are left wondering whether physicians must lead clinical care teams or whether nurses and other health professionals may lead.

The ACP is right to see the question of clinical care team leadership through the lens of medical professionalism. A notable strength of traditional care models is that they foster physicians’ sense of responsibility for patients under their care. The danger of any care model in which the caregiver is broadly conceived as a team rather than as an individual is the possible dilution of responsibility assumed by individual caregivers. Without safeguards, no individual member of the team may feel compelled to go the extra mile to ensure the delivery of necessary care. All members of clinical care teams must take responsibility for the care they deliver, and present levels of physician responsibility for care must not be diminished. What kind of team organization will achieve these goals?

The Institute of Medicine and the National Committee for Quality Assurance correctly state that administrative leaders of clinical care teams need not be physicians any more than leaders of group practices, hospitals, or other health care organizations need be physicians. Yet, medical professionalism requires that the person with the most clinical expertise be responsible for determining the strategy and tactics of care for the team’s patients. In most cases and for most patients, that professional will be a physician if the team has physician team members. In such well-functioning teams, clinical care will be coordinated and delivered by diverse health care professionals acting in concert according to plans on which physicians agree and for which they take responsibility. Any authority less than this for physicians in clinical care teams will subvert medical professionalism and patient welfare, which is its object. But this authority need not include administrative leadership of the clinical care team.

To say so much is not to maintain that primary care teams will necessarily have physician members. The ACP position paper proposes that in areas with a shortage of physicians, doctors should have a virtual presence on clinical care teams that lack a physician on the ground. Perhaps they should, but to suppose that they will is unrealistic. In 17 states, advanced practice nurses can already treat patients without physician involvement (8). With the primary care shortage about to worsen in the context of the Patient Protection and Affordable Care Act, the shift of primary caregiving to nonphysician providers will likely accelerate. A recommendation that states should not allow “health professionals to deliver [patient care] services for which they are not qualified” seems oblivious to this reality. The ACP correctly recognizes that “primary care” encompasses everything from the care of simple outpatient problems (which nurse practitioners are well-qualified to provide) to the care of complex problems (which require physician involvement). Given the breadth of primary care, licensure and regulation cannot restrain nonphysician primary caregivers from offering primary care services that they are not qualified to provide. Only professionalism will keep such caregivers operating within their sphere of
competence—as is the case for all clinicians, including primary care physicians. The ACP's effort should be to encourage such professionalism by ensuring that its members are available to consult with nonphysician primary care teams in amicable partnership. Such consultation will be essential for the proper care of patients who move from simple to complex primary care needs.

The ACP position paper states that students are not presently educated to participate in clinical care teams and notes that an expert panel has identified 38 competencies conducive to “essential behaviors” for good functioning on teams. The ACP calls for these competencies to be part of clinical training. While undoubtedly they should be, the ACP should not reinforce, even implicitly, current tendencies among educators to presume that specific behaviors exhibited in the proper context on given occasions signify competence (9, 10). The only way for health care professionals to learn to work on clinical care teams is to work on such teams during training. For that to happen in the context of internal medicine residency, resident clinics will need resources to function as patient-centered medical homes in which residents participate. In general, such resources are not presently available, and training for team membership will not happen until they are available.

The needed evolution of primary care to team-based care presents formidable challenges to internal medicine as it is presently practiced. Reimbursement mechanisms are likely to become obstacles to its development that are at least as important as the cultural and regulatory issues addressed by the ACP position paper. Although the principles offered in this paper will not “dissolve the barriers” hindering the evolution of clinical care teams (1), they do offer a useful first step toward addressing the problems that internal medicine will face in adapting to team-based practice.

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Potential Conflicts of Interest: None disclosed. Forms can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M13-2032.

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This article was published online first at www.annals.org on 17 September 2013.


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