VIEWPOINT

Contemporary Multidisciplinary Care—Who Is the Captain of the Ship, and Does It Matter?

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"But it's my patient, I'm the one who has to answer to the family and who gets sued."

This is the battle cry most often heard in the intensive care unit (ICU) when physicians reach loggerheads about who should be directing care. The captain of the ship doctrine, although now largely discredited in medicolegal status, was first applied to medical practice in *McConnel vs Williams*.[1] We argue that times have changed and changed permanently. In an era of team-based care, the question of who is captain of the ship is too often a distraction and, more importantly, does not contribute to good patient management.

To be clear at the onset, we are not advocating for an abdication of personal responsibility. It is unarguable that patients feel best when they have a strong bond with a principal in the delivery of their care and can trust that individual to provide consistent oversight and be mindful of their preferences. That said, it is our contention that delivering on these commitments requires skill in teamwork, communication, and consensus-building and less focus on minute-to-minute management and "who is in charge." Indeed, any time spent arguing the latter point subtracts from the more important actions at hand.

The reason for this shift in emphasis is reflected in the way that medical practice has evolved. Physicians do not generally provide the same type of continuous care to their patients as they have in previous eras. For example, in operative or other invasive interventions, the attending surgeon of record is mandated to be present for the "critical portion" of any procedure and be available for urgent needs throughout. Still, when challenging procedures are completed, care is nearly always handed over to an ICU team that carefully monitors and treats a wide range of issues, albeit with input from the proceduralists. Such ICU environments involve a complicated dance of overlapping team-based care activities incorporating intensivists, fellows, residents, midlevel professionals, nurses, pharmacists, physical therapists, nutritionists, and others.

We submit that this is just how it should be. Procedures have become more complex, and the patients undergoing them are sicker. Sick patients require constant care. The risks of fatigue and burnout mandate that one person cannot and should not do it all. To enable the best outcomes and the most sophisticated management, a reliable system of care is needed, with organizational characteristics that favor successful integration of multiple skill sets and rapid resolution of any conflicts. Most simply, physicians with highly specialized skills must interact in a collegial but nonhierarchical fashion.

What accounts for the persistence of the captain of the ship doctrine and attendant conflicts over it? Two observations inform this question. The first is that identification of who is directing all care only becomes controversial when there are breakdowns in communication. It is no coincidence that perhaps the most intense disagreements about who is in charge occur in ICUs, where the most complex patients receive care from the largest number of overlapping specialties.

Such conflicts are rarely the result of irreconcilable differences in opinion about how care should be delivered. They are almost always the result of a violation of what the medical sociologist Charles Bosk labeled the "rule of no surprises."[2] This occurs when something unexpected has happened, or care has been delivered in a way that surprises a physician who reasonably had an expectation of being informed or participating in the decision-making process (a "normative" deviation, in Bosk's classification). The actual decision making and delivery of care may be flawless, but the surprise element drives the conflict. The response then becomes misdirected, focusing on the question of who is in charge instead of why communication broke down. Importantly, the root cause of failure in such instances is not a leaderless system, but one in which coordination of care has been disrupted. The demand to know who is in charge rarely occurs when patients are receiving the multidisciplinary care they need and the various health care professionals involved are communicating and coordinating with each other.

The second reason that the captain of the ship philosophy is still invoked has to do with the nature of the informed consent conversation. Instead of including all of the physicians who will be involved in care, it is generally conducted only by the one physician planning on performing a procedure. This too is a historical artifact. The doctrine of informed consent as we use it today was formulated at a time when medical practice was simpler and the physician-patient dyad was the fundamental model of care. The legal scholar and physician Jay Katz lamented in 1998 that physicians had failed to fashion the "doctrine" in a way that was responsive to the realities of practice(s), as had been the intent of the judges who originally promulgated the concept in case law.[3] If that was true in 1998, it is even more so now.

Patients ought to be informed that they will be entering into a matrix environment in which multiple professionals will provide care at differing stages of treatment and recovery. In the case of a patient scheduled for surgery, this includes at a minimum the surgeon, anesthesiologist, their residents, physician assistants, nurses, and anyone else who plays a role in ensuring the success of an operation. The patient should be cognizant of

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the realities of modern in-hospital medical care; a substantial amount of perioperative care will be provided by health care professionals not specifically known to them. When done properly, we believe that this form of multidisciplinary team-based care is the key to good health care delivery and need not interfere with the primary physician-patient relationship and the responsibilities therein.

There are numerous advantages of such an approach. Most obviously, a good "handoff" or transition in care from one physician to another is the opportunity for a fresh overview of a patient's condition, with the potential for recognizing previously undetected problems or amending a care plan. Central to such an effort is good communication and coordination. We need to invest in greater resources to help all physicians master these critical skills.

What can be done? As a first step, hospital leadership should better incentivize and reward good teamwork and communication. Skill sets involved in effective teamwork and communication should be viewed similarly to procedural skills[4,5] in that they both require training, repetition, supervision, and mentoring for individual physicians and teams. The training should include emotional intelligence exercises.[4,6,7] The increased availability and capabilities of clinical simulation laboratories can make such interdisciplinary instruction especially powerful.[8]

The administrative structure in which teams work should also be designed to support desired attributes. This may take the form of colocating team members, both physically and administratively, in institutes, centers, or other consolidations that focus on a specific disease process, eg, a heart institute that houses cardiac surgery, cardiology, cardiac anesthesiology, and cardiac ICU. Finally, financial incentives in yearly bonuses, increased individual and team responsibility, and peer recognition should be forthcoming for outstanding team-based outcomes. This process will mandate explicit metrics and accountability in this area.

While some look back wistfully at the days when a single physician took ongoing care of an individual patient despite the prolonged work hours, this model had its own problems. For better or for worse, it is undeniable that it has now been replaced. The concept of the captain of the ship in medical practice requires similar major revision.

ARTICLE INFORMATION

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