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RHETORICAL STRATEGIES IMPLEMENTED BY THE AMERICAN
MEDICAL ASSOCIATION TO IDENTIFY ROLES WITHIN THE
INTERPROFESSIONAL HEALTHCARE TEAM

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ABSTRACT

Purpose: Healthcare reform is introducing new models of care to serve complex patient needs, including expanded roles for nursing. This has resulted in interested parties debating formal definitions of provider roles in healthcare teams. The purpose of this study is to conduct a rhetorical criticism of content produced by the American Medical Association (AMA) concerning the role of providers within the healthcare team.

Theoretical/Conceptual Framework: This study's framework uses rhetorical criticism, an analysis of an organization's "strategic use of symbols to generate meaning" (Hoffman & Ford, 2010). This analysis evaluates the rhetoric on its potential function both to influence the definition of provider roles and to critique how the organization's potential power may be implemented. By understanding what the organization displays in its public texts, one can potentially infer the intentions of the organization.

Method: Press releases and newsletter articles publicly available from the AMA website from 2010 to 2014 were selected based on their relevance to the discussion of healthcare team leadership. The texts were analyzed using a systematic approach to identify and describe rhetorical strategies. This is a systematic, rigorous method for deconstructing texts in order to draw conclusions about the choices a rhetor made in achieving a goal. The analysis was then further enhanced with relevant contextual and historical research, analyzing the development of health care professions as disciplines in the US, and the organization's history itself in its development as a trade association.

Results: Rhetorical strategies used by the AMA include: Appealing to the values of patient safety, teamwork, and competent leaders of teams; and making logical arguments based on contradictions in lay definitions of teamwork and independence. These are used to argue for maintaining legal and financial interests for physicians within healthcare systems. Limitations include analyzing select materials publicly available without an AMA membership.

Conclusions: Defining the role of members within the interprofessional team is of interest to healthcare providers and their representative organizations as new models of care attempt to increase quality, access, and value within the system. As nursing organizations attempt to expand nursing scope of practice at the state level, oppositional views of these bills should be understood to provide counterarguments and effectively engage stakeholders.

INTRODUCTION

Healthcare teamwork has been a much-discussed subject in recent years as a way to improve the quality of care offered, particularly in primary care. Teamwork and collaboration among different professions within the healthcare setting are cited as practices contributing to positive patient outcomes in the clinical setting (IOM, April 2010). While these concepts are receiving renewed focus in contemporary discussions of health care policy, these concerns have been seen for years, with the World Health Organization calling for increased interprofessional education and teamwork as early as 1973 (Lapkin, Levett-Jones, & Gilligan, 2011). Amid shortages of primary care physicians dating back to the 1950s, the creation of the professions of nurse practitioner and physician assistant through formal educational programs began in 1965, offering increased quality and value for underserved populations (Cawley, Cawthorn, & Hooker, 2012).

In 2010, the passage of the Affordable Care Act (ACA) not only mandated increased health insurance coverage in the United States, but it also called for increased funds to train nurses and nurse practitioners (Kaiser Family Foundation, 2013). After the end of the first open enrollment period in 2014, approximately 9.5 million fewer adults were uninsured compared to the previous year (Commonwealth Fund, 2014). While some feel the current healthcare workforce can handle a steady short-term increase in outpatient visits from the newly insured (Commonwealth Fund, 2015), many are concerned about the system's long-term solvency. An aging healthcare workforce and aging population as a whole (National Governors Association, 2012), lead some to predict that the healthcare system will create up to 1.05 million new registered nurse positions by 2022 (BLS, 2013), and between 12,500 and 31,100 primary care physician positions to fill by 2025 to keep up with demand

(IHS, 2015). The Affordable Care Act also placed an increased emphasis on providing higher quality healthcare for a greater value through several means, including national strategies for patient outcomes and quality improvement, and value-based purchasing programs to hospitals accepting Medicare patients (Kaiser Family Foundation, 2013).

Recent rethinking of how to provide comprehensive primary care has also led to an increased interest in teamwork and leadership. The concept of the Patient Centered Medical Home (PCMH) is one model of primary care delivery emphasizing teamwork among different professions in order to provide more coordinated and comprehensive care. The concept was first introduced in the 1960s, yet gained the increased attention of medical organizations and insurance companies through the 1990s and 2000s as a way to revive and improve primary care (Robert Graham Center, 2007). In 2007, several medical organizations, including the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association, introduced seven key principles for PCMHs to follow; one of these explicitly states that physicians lead the medical home (Patient Centered Primary Care Collaborative, 2007). Accrediting bodies were interested in certifying these organizations; the Joint Commission chose to start accrediting PCMHs that had nurse practitioner leaders in 2011 (Joint Commission, 2014).

In 2008, the Robert Wood Johnson Foundation (RWJF) approached the Institute of Medicine (IOM) to initiate a partnership exploring challenges to the nursing profession providing quality care in the 21st century, called the RWJF Initiative on the Future of Nursing. The site meetings culminated in *The Future of Nursing: Leading Change, Advancing*

Health, often referred to as the *Future of Nursing* report. This text provided recommendations on changes that may benefit nursing in the areas of education, practice, leadership, and data collection. One recommendation was for scope of practice laws to be changed allowing advanced practice registered nurses (APRNs) to practice to the full extent of their education and training.

Following the report's publication, the RWJF and AARP backed The Future of Nursing: Campaign for Action, a website (championnursing.org) central to the campaign of implementing recommendations from the IOM (RWJF, 2015). Among many recommendations, activities included forming state coalitions to advocate for legislation allowing APRNs to practice to the full extent of their training; since 2010, several states have passed model legislation stemming from the APRN Consensus Model (National Council of State Boards of Nursing, 2015). Currently nurse practitioners working in 20 states and the District of Columbia have full scope of practice based on their education and training, with many states still debating this issue (American Association of Nurse Practitioners, 2015).

While the IOM (2011) stated that barriers exist to expanding scope-of-practice for APRNs, including from medical organizations, it did not go into specific detail about these groups' actions. After study of the aforementioned report from the IOM, the author became curious as to the reaction and opinions of other organizations that may be opposed to independent practice for APRNs in states currently requiring more collaborative or supervisory roles with physicians. Due to state, organizational, and professional differences involved, this quickly becomes a complex issue to tackle. For purposes of this study, one

organization was chosen as an exemplar for how healthcare team communication is communicated at the professional organization level. The American Medical Association (AMA), a trade organization dedicated “to promote the art and science of medicine and the betterment of public health” through providing information and advocacy to physicians and medical students (AMA, 2015), was chosen due to its size, history of physician advocacy, and availability of information concerning healthcare teams on its website.

The purpose of this study is to conduct a rhetorical criticism of select content produced by the AMA concerning the role of providers within the healthcare team. In addition, the study provides relevant historical and contextual background on why the AMA may have chosen this rhetoric at this particular time.

METHODS

RESEARCH METHODOLOGY

This study’s framework uses rhetorical criticism, an analysis of an organization’s “strategic use of symbols to generate meaning” (Hoffman & Ford, 2010, p. 2). This type of analysis dates back to Aristotelian judgment of public speeches based on ethos, pathos, and logos. Contemporary rhetorical criticism modifies this approach to incorporate rhetoric found in modern-day forms of communication on the Internet, newspapers, television, and radio. Both are ways to analyze messages, which is particularly useful when evaluating the rhetoric produced by organizations. An organization, as defined by Hoffman and Ford (2010), is a group of people with three characteristics: a common purpose, a willingness to cooperate, and communication. They are formed to help people reach goals they cannot accomplish alone. Businesses may be the first organizations that come to mind, but the

term may also include schools, faith-based groups, trade associations, and other groups meeting the criteria above. As “the largest producers of rhetoric in contemporary society” (p. 17), studying what an organization chooses to display in its public texts can help one infer the intentions of the particular organization in question, and may help one become a better consumer, employee, and/or member of society.

Rhetorical criticism is conducted using a multi-step, qualitative process (Ford, 1999). First, the critical problem is defined, either through defining interesting texts produced by an organization, or by studying a theory or method question. Next, texts are selected for research based on their relevance to the problem, representativeness, immediacy, and distinctiveness. Third, the texts are analyzed using an open-ended analysis (see Analysis Worksheet, Appendix C). Fourth, relevant contextual, historical, and theoretical research is conducted to give organizational context as to why this organization is using this rhetoric at this time. Finally, an explanation and evaluation of the rhetoric presented by the organization in question is developed (for more detail, see Appendix B).

This framework may be used to analyze groups for differing reasons, including how corporations’ views of work/life balance may reinforce views of traditional family structures (Hoffman & Cowen, 2008), or to see how public communication by trade associations affect national healthcare policy (Ford, 1999). The intention of using this framework for texts produced by the AMA is to analyze this group’s potential function to influence the definition of provider roles at the state and organizational level, and to critique how their potential power may be implemented through policy.

Sample Texts

Texts were initially chosen by searching the AMA's website (ama-assn.org) for "physician led teams" or "team based healthcare" in September 2014. Results yielded information from two sources on the site: a web page with links to additional documents on the topic, and archived press releases from the AMA Wire section of the website. The AMA Wire texts could be obtained publicly; most linked texts from the Physician-Led Teams page required a free registration with an email address to obtain access. Three documents on the latter page were linked, yet stated they could only be accessed through logging in as an AMA Member. The titles of these documents were searched using Google; this yielded a link to a Physician Led Teams page on the site of the American Association of Clinical Urologists (aacuweb.org), which had PDF links to the texts in question. Texts were collected until about 25 pages of material were found, totally fifteen separate documents (for a full list, see Appendix A).

While all of these texts were accessible in September, it should be noted as of writing in April 2015 that many of these texts are no longer publicly available. Many texts that were formally available with an AMA public login now require login as a registered AMA member to access. In addition, press releases before August 21, 2013 have been cached and are no longer accessible from the AMA Wire.

ANALYSIS

After the texts were chosen and read, an analysis worksheet adapted from Hoffman and Ford (2010) was used to deconstruct the texts (see Appendix C). The worksheet captures information on several aspects of the text, including goals, ethos, pathos, logos, and strategies.

The first heading, Goals, looks at themes present in the document, as well as the text's requested purpose or action. Next, Ethos, or the appeal to credibility and to community, is analyzed to see if the text displays the organization's competence to speak towards the theme presented and/or whether the text shows that the organization displays their credibility through community involvement.

The next worksheet heading involves Pathos, or the appeal to emotions. This may be achieved through a combination of addressing needs the organization has identified, stating or implying values that may be common between the organization and the reader, and identification with those individuals or groups that may be for or against the rhetoric presented. Logos, or the appeal to logic, is seen in the text through claims, quantitative or qualitative evidence supporting their requested actions, and logical arguments presented. Logical arguments may be either inductive or deductive in nature. Inductive reasoning uses a specific instance to reach a more general logical conclusion, while deductive reasoning uses a general idea to arrive at a conclusion in a specific instance.

Finally, strategies implemented in the text are documented, including the organization of information and appeals in the text. For web-based materials, this also includes their organization and navigability within the organization's website. In addition, language and visual choices, as well as organizational branding, are noted. Finally, strategies for delivering appeals, such as in what form of communication the rhetoric is presented, is noted for reference.

CONTEXTUAL AND HISTORICAL RESEARCH

A number of historical research threads were perused, including: The history of the AMA in its development as a trade association, the growth of the nurse practitioner profession, and the relationship between the medical and nurse practitioner professions in the United States. In addition, contextual research pertained to: the ACA and its resulting potential client base, the numbers of healthcare providers available to provide needed and desired primary care, and examples of health care organizations that currently subscribe to the physician-led team model. Other contextual research was conducted surveying examples of states that have legislated team-based healthcare models in accordance with AMA recommendations, and other organizational views of team-based care, including The Institute of Medicine, to which the AMA may be responding.

RESULTS

TEXT ANALYSIS

Fifteen online documents published by the AMA were analyzed, ranging in published date from October 2010 through 2014 (Listed in Appendix A). The earliest document outlined the AMA's response to the recently published *Future of Nursing* report from the IOM (Patchin, 2010); the newest announced that the organization had voted on an official definition of physician-led team-based healthcare (AMA, 2014 June 9). Other texts covered diverse topics pertaining to healthcare leadership and teamwork, including the following: a model bill for physician led teams in healthcare to be implemented by state legislators (AMA, 2011); an outline of the AMA's principles and policy stance on this issue in general (AMA, 2012 November 13; AMA, 2012); on patient centered medical homes (AMA, 2013 April 17), recommended payment models for healthcare teams (AMA, 2013 November 13),

and letters to state lawmakers (Madara, 2014; Hoven & MacLeod, 2014). Most texts were less than one printed page in length; the longest text was a 12-page *Best Messages* document dividing 17 key messages into short points for different public target audiences (AMA, 2012),

Repetitive language was used across different texts, such as letters written to state legislatures or the Veterans Health Administration (VHA) using text verbatim from an *Issue Brief* (AMA, et. al, 2013 October 28; Hoven & MacLeod, 2014; Madara, 2014). This would be expected, as repetitive messages from an organization are key in order to ensure they are presenting consistent information to their stakeholders.

The focus of the documents was almost exclusively on the scope of practice of nurse practitioners, as opposed to other APRNs such as nurse anesthetists, clinical nurse specialists, or nurse midwives; APRNs as a whole are mentioned when addressing the VHA. One document consistently used the word “nurse” while referencing roles performed by APRNs (AMA, 2012).

Goals of the texts were straightforward: The AMA advocates for implementation of its concept called “physician-led team-based care”. This is defined as:

The consistent use by a physician of the leadership knowledge, skills, and expertise necessary to identify, engage, and elicit from each team member the unique set of training, expertise, and qualifications needed to help patients achieve their goals, and to supervise the application of these skills (AMA, 2014 June 9)

Themes stated that physician-led teams are working in selected organizations, including: Blue Cross Blue Shield of Michigan (AMA, 2013 September 18), Geisinger Health

Systems, the Mayo Clinic, Kaiser Permanente, and Intermountain Healthcare (AMA, 2013 October 28). In addition, they emphasize their view that independent APRN practice, particularly by nurse practitioners, is not compatible with healthcare teams. Requested actions involve advocating for physician-led team-based healthcare as defined by the AMA. All are written in an expert role, for an implied audience of AMA members interested in advocacy, as well as media and other interested members of the public.

Ethos of the AMA's texts focused on the AMA's competence to advocate for physician leaders of the healthcare team. The AMA texts state that physicians are the most competent leaders of the healthcare team; their education, training, and stature means they are best suited to judge other healthcare team member's competency and skill to perform collaborative tasks (AMA, 2013). Clinical competence of providers was heavily emphasized against length of education in multiple documents. The AMA states its competence to provide for advocacy in this area by the legal and financial resources available to support physician advocacy at the state and organizational level, and they are prepared to wield that power for the benefit of physicians and, ultimately, for patient safety. They refer to internally financed studies and opinion polls stating that the public shares their views (AMA, 2012), but study details are not publicly available.

Pathos, or appeals to emotions, was emphasized in the texts through appeals to public knowledge of what healthcare professionals do, that physicians have education and training that uniquely qualifies them to make healthcare decisions, and references to their high stature in society. Concepts of teamwork and the necessity of strong leadership in other areas of society, such as business and athletics, were cited, followed by statements

that physicians are in the best position to apply this role in healthcare (AMA, 2013). Differences in educational methods and possible public confusion are exploited in cited data, such as comparing hours of training between physicians and nurse practitioners by comparing hours for both medical school and residency training with the clinical hours a NP would experience only in a master's level program (AMA, 2012), excluding BSN clinical hours, work experience before graduate school, or additional hours obtained in post-master's or DNP courses. The texts appeal to patient safety through advocacy in the area of scope of practice laws, which have traditionally been in place to protect the public (Marquis & Huston, 2015). Well-known organizations, such as large healthcare organizations and other medical specialty groups, are praised for upholding similar values to the AMA, and for collaborating with the AMA to get this message across (AMA, 2013 October 28).

Analyzing logos, or the use of claims, evidence, and logic, yielded multiple examples of arguments made by the AMA to support their view. Two main logical claims were present throughout several documents. The first again referenced educational differences between nurse practitioners and physicians. It argues that the public generally views leaders as having a great deal of education and experience; meaning, as physicians are generally in school for a longer period of time, they are more qualified to be a leader (AMA, 2014). In addition, a reoccurring argument attempts to present nurse practitioner independence and healthcare teamwork as incompatible (Madara, 2014). By showing a contradiction between the colloquial definitions of the two terms, the organization ultimately tries to claim that independent practice by nurse practitioners cannot logically fall under the concept of teamwork, and is the antithesis of a healthcare system moving towards team-based models.

Other logical arguments cited by the AMA in its “Best Messages” text (2012) include that patients like physicians leading the healthcare team, therefore physicians should be the team leader. In addition, despite claims that savings from hiring a nurse practitioners may lead to decreased outcomes for patient safety, it is stated elsewhere that more nurses practicing independently leads to more liability insurance purchased, thereby increasing healthcare costs (AMA, 2012).

In addition, the AMA also argues that leadership and management are used interchangeably and cited as roles that are often placed upon the same person in an organization (AMA, 2012, November 13). Other claims include: nurses are “helpful” to the team and should “assist the physician” (AMA, 2012), and nurse practitioners provide care that is less safe than physicians due to having fewer years of training (AMA, 2013, April 17). A text also discussed recommendations for payment of the healthcare team, calling for the physician leader to receive the payment and “establish payment mechanisms that foster physician-led team-based care” (AMA, 2013 November 18).

Statistics from studies conducted by the AMA include stating that 75% of patients prefer their health team to be led by a physician as opposed to a nurse (AMA, 2012). They also cite savings of \$310 million over a five-year period within Blue Cross Blue Shield of Michigan when they started using patient centered medical homes, justifying a model of physician-led teamwork (AMA, 2013, September 18).

The texts ultimately point to a standardization of a state-level advocacy campaign that aims to legally define the definition and execution of team based healthcare according to physicians represented by the AMA. Repetition and standardization of terms helps to

create unifying symbols of physician-defined collaboration, tying the theme of increased quality in healthcare and patient safety together.

HISTORICAL BACKGROUND

The AMA's mission statement is "To promote the art and science of medicine and the betterment of public health" (AMA, 2015). It has approximately 225,000 physician and medical student members (Stack, 2013), representing approximately 15% of American physicians, down from a high of 75% of the profession in the 1950s (Collier, 2011).

Founded in 1846 to advocate for increased quality of medical education and ethics, it grew throughout the early 20th century as a dominant representative of allopathic medicine (Ford, 1999). The organization has a history of advocacy for physicians and the health care system as a whole. It historically has taken conservative measures in healthcare reform to benefit physicians under the guise of patient safety and upholding the physician-patient relationship. Despite its history opposing governmental health care, the association did interestingly endorse passage of the Affordable Care Act (Collier, 2011). Other recent advocacy issues the AMA has been involved with include reforming Medicare payments to physicians through elimination of the SGR formula, and truth in advertising campaigns as more health professionals require or offer doctoral level degrees as entry into practice (AMA, 2015).

The AMA has a pattern of rhetorical strategies seen in past advocacy efforts that seem to carry into their current views of team leadership. They ran successful campaigns opposing national health insurance in the late 1940s-1950s based on an organizational resolution framing national health insurance as infringing on a patient's right to choose the

physician they wished, when the organization actually opposed governmental influence on physicians and competition from voluntary physician-run insurance plans (Ford, 1999). In 1965, as Medicare was being debated and interest in offering coverage for senior citizens was high, the AMA offered an alternative program called Eldercare, trying to influence governmental regulation by providing a voluntary insurance coverage option for seniors. Medicare's implementation, growing economic inflation, increased interest in socioeconomic inequities, and structural reform of Congressional committees' spreading influence over more subcommittees and chairs meant that the AMA began to lose influence as a dominant player in national healthcare policy at this time. Sympathetic Congressional committee members lost their influence in a new legislative structure, and public favor for physicians decreased due to their high income. The AMA continued to provide influence and counterstrategies in healthcare policy debates, ensuring they had a plan to counter any increase in governmental healthcare or increased oversight of healthcare costs.

Medical practice acts, when first enacted in the late 19th century, tended to include broad classifications of what kind of healthcare physicians could provide, giving the profession power to define healthcare policy and delivery. Since then, adjustments to healthcare professional practice acts have tended to "carve out" healthcare tasks that APRNs, optometrists, pharmacists, and physical therapists, among others, are qualified to do. This leads to conflict between these professions and what state medical societies consider to be the sole purview of physicians' work (Fairman, 2008).

Healthcare providers that are not physicians have been seen throughout history in areas with great need, from feldshers in Russia (Andrus & Fenley, 1975), to barefoot

doctors in China (Cawley et. al, 2012), to American military corpsmen serving their fellow soldiers (Rousselot, Beard, & Berrey, 1971). Concerns about healthcare professional shortages abounded in United States in the mid-20th century, with the per capita number of physicians dropping 149 per 100,000 Americans in 1909 to 133 per 100,000 in 1959 (American Medical Association, 1960). While the per capita number of nurses increased from 89 to 268, there was a consensus that there still were not enough nurses to meet healthcare demands. The growing post-war economy and expansion of health insurance benefits, increased physician specialization, and medical advances increased demand for healthcare, making it hard for generalist physicians to keep up (Fairman, 1999).

There was a tacit acknowledgement that nurses and other healthcare workers in areas with physician shortages were informally trained by physicians to perform tasks legally under the purview of medicine, potentially exposing them to prosecution by state medical boards (Andrus & Fenley, 1975). Interest in creating formal education programs and licensure for these “assistants” or “associates” of physicians was high (Cawley et. al, 2012). The first formal training programs for both nurse practitioners and physician assistants were started in 1965, at the University of Colorado and Duke University, respectively (Nuckolls, 1974); programs for both were quickly created after this at various universities throughout the 1960s and 1970s.

These new professions were immediately seen as beneficial for providing healthcare to underserved populations, yet control over their scope of practice and their relationships with other healthcare team members met with controversy from both organized medicine and organized nursing. Physician groups sought “assistants” well versed in the medical

model to receive delegated tasks. The AMA endorsed the profession of physician assistant in 1969, largely because of their training under the medical model and that physicians had more direct control over their practice (Cawley et. al, 2012).

Nursing as a profession had been evolving from a group of workers carrying out delegated tasks into professionals making decisions about patient care in their own right. The International Council of Nurses even took the step of removing any language defining the profession as being under physician supervision in the 1960s (Lynaugh, 2008). Nursing groups, particularly the American Nurses Association (ANA) and the National League of Nursing (NLN) at the time felt threatened that the medical profession was trying to co-opt their own; some leaders went so far as to disown nurse practitioners as members of the nursing profession (Rogers, 1972), and rebuffed attempts at consensus at the organizational level from even sympathetic physicians (Christman, 1998). These were not fears without context, as the AMA had a Committee on Nursing at the time offering advice on how the nursing profession could help physicians (AMA, 1970), and reportedly stated interest in converting 100,000 registered nurses into physicians' assistants (Nuckolls, 1974). While some organized nursing associations began to recognize that advanced practice nurses could bring both medical training and a nursing background to help care for patients in an expanded nursing function, the sentiment was not widespread in the infancy of the nurse practitioner profession (Andrus & Fenley, 1975).

CONTEXTUAL BACKGROUND

In addition to the publication of the *Future of Nursing* report (IOM, 2011) and the passage of the Affordable Care act in 2010, other events in health policy occurred that were mentioned within the texts that the AMA chose to respond to.

As discussed earlier, Patient Centered Medical Homes (PCMHs) were designed by medical organizations to explicitly be physician-led (Patient Centered Primary Care Collaborative, 2007). As their prominence increased, accrediting bodies became interested in certifying PCMHs as well. In 2011, the Joint Commission decided to accredit PCMHs that are APRN-led, without collaborative or supervisory agreements, as state law allows (Joint Commission, 2014). They do require a physician to be a part of the patient care team, but their involvement may be “determined by the needs of the patient.”

The AMA cited several large health care organizations as examples of health systems that effectively subscribe to the physician-led team model. Finding publicly available information from these organizations to confirm their views produced mixed results. Geisinger, a health system in Pennsylvania, explicitly states on its website that “a physician-led approach to healthcare” is a value of the organization (Geisinger Health System, 2015). It is also lauded for its dedication to use nurse practitioners to the full extent of their education and training, even starting one of the country’s first NP-staffed urgent care clinics (IOM, 2011). Intermountain Healthcare, serving Utah and southeastern Idaho, does not explicitly state “physician-led teams” in its vision statement, but does emphasize engagement of physicians into teams and respect for physicians’ clinical skills (Intermountain Healthcare, 2015).

Blue Cross Blue Shield of Michigan publicly displays its data on the quality and value of its Patient Centered Medical Homes run by primary care physicians (BCBS of Michigan, 2014) that are subsequently cited by the AMA (AMA, 2013, September 18). A reason for the emphasis on physician leadership in the PCMH may be that Michigan's nursing scope of practice laws are considered restrictive by AANP (2015), and may not allow for NP led PCMHs in this state. Kaiser Permanente's site states that "physicians are responsible for medical decisions" (Kaiser Permanente, 2015), although it has also been reported that they have piloted NP-led teams in prenatal clinics in Colorado with success (National Governors Association, 2012). Mayo Clinic's website does not explicitly state its views on physician leadership in its mission statement, but a search of the site yielded the term on pages such as for medical student clerkships (Mayo Clinic, 2015).

In response to concerns from organized medicine on calls for APRN expansion listed in the *Future of Nursing* report, the RWJF convened a summit of several leaders of nursing and medical organizations in 2011. The goal was to produce a consensus report between the professions (RWJF, 2013). While a confidential draft report was created, it was leaked at an AMA meeting that fall; the AMA's reported displeasure at both the content of the draft and their lack of invitation to the meetings led to the summit's abolishment. Only summaries and highlights from the meetings have since been published.

The National Governors Association Report (2012) encouraged its members to consider APRN practice expansion to bring more health coverage to states. As part of their report, they conducted a literature review comparing NP and physician quality in primary care—they didn't find differences between the two types of practitioners, but stated that more

research is needed comparing health care quality in states with differing NP scope-of-practice laws.

SUMMARY OF RESULTS

When reading one press release from the AMA, the reader can get a sense of their opposition to expansion of practice for APRNs. When analyzing several texts, the historical background of the AMA and these healthcare professions, and looking at the context of American health care policy in 2010, it appears that a much larger campaign is occurring. It seems that the American Medical Association is conducting a campaign to legally define their views of the physician as the leader and supervisor of the healthcare team, particularly the primary health care team. This would therefore ensure physicians are uniquely qualified to make the final decisions regarding collaboration, scope-of-practice, and financial compensation of the team members, including other professions, within their organization.

During this time period, not all states passed legislation in line with the IOM and RWJF recommendations. Some AMA sample texts cited Virginia and Texas as both passing legislation aligning with the AMA's advocacy goals (AMA, 2013, September 18). Virginia's bill incorporated language directly from the AMA model bill (*HB346: Nurse Practitioners*, 2012), thereby legally defining teamwork and collaboration within the AMA's interests. In 2013, Texas passed new legislation concerning the number of nurse practitioners one physician could enter into a practice agreement with (*SB406: An Act Relating to the Practice*, 2013). Interestingly, the legislation did not include language from the AMA model bill. Of note, however, is that both the old and new Texas practice acts emphasize the use of

“delegation” from physician to nurse practitioner, rather than “collaboration” between the two professions. Many of the analyzed texts used “collaboration” to describe work among healthcare team members, but the definition adopted by the AMA (2014, June 9) ultimately uses the word “supervision” to describe the interprofessional relationship. The American Association of Nurse Practitioners (2015) categorizes both Texas and Virginia as having “restrictive practice” for nurse practitioners.

DISCUSSION

The AMA has produced a strategic counterargument for the expansion of nursing scope-of-practice laws. The IOM (2011) published a comprehensive report that led to strategic campaigns across the country aiming to change scope of practice laws for APRNs. As this research has shown, the AMA has organized a strategic campaign of their own that not only opposes bills for nurse practitioner independence, but also provides counter-legislation ensuring that views supported by the AMA are placed into state law. This legislative victory for the AMA has, at this point, occurred in Virginia.

However, the AMA’s rhetorical campaign does not appear to have gained much traction in passing model legislation at present. As of this writing, no other states besides Virginia have passed the AMA model legislation. In Nebraska, despite AMA advocacy against expansion of nursing scope of practice (Madara, 2014), legislation was passed in March 2015 allowing NPs in the state independent practice after serving 2,000 hours in a collaborative transition-to-practice agreement with a provider in the same specialty (*LB107: Eliminate Integrated Practice*, 2015). The American Association of Nurse Practitioners has its own advocacy center on its website, highlighting bills in 16 states for

the 2015 Legislative session concerning expansion of APRN practice, including in Texas (AANP, 2015).

Many of these bills attempt to lessen or abolish collaborative practice agreements between nurse practitioners and a physician (AANP, 2015). Collaboration is a politically charged word among healthcare providers; it is often used in a regulatory sense to describe roles between nurse practitioners and physicians in a supervisory manner (Anonymous, 2004). Among other healthcare professionals, and nursing in particular, collaboration is viewed in a less hierarchical manner. The sharing of information and working together to bring the best expertise for patient care is a fundamental part of nursing practice, and a trait that helps nurses and APRNs successfully care for patients when they are practicing in expanded roles, such as caring for chronically ill patients (Fairman, 2008). This makes the AMA's logical argument of nurse practitioner independence opposing collaboration nonsensical. As cited previously, organizations interested in healthcare policy such as the AARP, the National Governors Association, the Joint Commission, and the Robert Wood Johnson Foundation, among others, have all publicly stated support for at least considering expansion of APRN roles within the context of collaboration in a less hierarchical environment, in contrast to the views of organized medicine.

One of the guiding principles of the AMA is that "physician leadership is critical to the successful evolution of health care in a patient focused delivery system" (AMA, 2015); as with any trade organization, it would be assumed that the AMA would advocate for its constituents when their particular industry and livelihood is undergoing change. One must question, though, where the line is between a group advocating for its cause, in this case

patient care and safety, and when the group is advocating for its own interests, particularly if the group's interests are concealed as benefitting patients.

Leadership interestingly does not have a single definition, although leaders are often identified as, "those individuals who are out front, taking risks, attempting to achieve shared goals, and inspiring others to action." (Marquis & Huston, 2015, p. 34). In order for leadership to be effective, it also requires power from some kind of source for support; one particular form is expert power, that which is wielded by someone with critical knowledge that others in the group may not have (Marquis & Huston, 2015). Due to education in the basic sciences, scope of practice laws, and tradition, physicians have held expert power within the healthcare hierarchy. Throughout the rest of the twentieth century, and continuing to the present day, attempts to reform nurse practice acts to expand APRN scope of practice have been blocked by state medical societies steeped in a worldview viewing nursing as having inferior education, particularly in the basic sciences (Fairman, 1999). Due to the complexity of 21st century healthcare, there has been increasing acknowledgement among stakeholders within the healthcare system that, while some medical organizations wish to keep physicians' formal leadership as the status quo, everyday practice no longer adequately works with a "captain of the ship" model at all times (RWJF, 2013).

This project shows how important semantics is, and that new models of healthcare need standards and definitions to frame how that care is provided, since they may require changes in legal policy, organizational structure, or protocols. Laws may not be repealed easily, and the type of legislation advocated by the AMA may have consequences for

innovation of new and emerging models of care in order to satisfy demand from various patient populations.

As nursing organizations attempt to expand nursing scope of practice at the state level, oppositional views of these bills should be understood to address concerns, provide counterarguments and effectively engage stakeholders. One area this research has highlighted is that the diversity of educational degrees and requirements available for registered nurses and APRNs can lead to confusion, and subsequent exploitation of this confusion, by opposing parties in the debate over scope of practice changes. Media campaigns explaining nursing education, and continued work in standardizing nursing education and certification, may help to clarify this point for all registered nurses, including nurse practitioners. This counterargument is one with precedence; the IOM (2011) also addressed the need to standardize nursing education, and recommended requiring the baccalaureate degree as the minimum entry to practice and the DNP as entry to advanced practice. These recommendations, while having controversy of their own within the profession, would also help to more clearly articulate how nurses are trained for careers within an ever-evolving profession.

LIMITATIONS

There are several limitations with this project due to the narrow scope of viewing a complex topic within current healthcare policy. First, even during the initial analysis of texts, there were a limited number of materials available on the AMA website without an AMA membership. The nature of this research method arrives at rhetorical conclusions in the role of an informed observer or consumer; another approach, such as a journalistic

investigation using first-hand accounts and internal documents, may give more insight into the AMA's values and intentions. In addition, this project has a narrow focus of a complex topic involving different professional organizations, state legislatures, and regulatory bodies; it may be so narrow as to be overly critical of the AMA's roles and responsibilities within a likely broader campaign of organized medicine, an example of "use of one case" (Ford, 1999).

Future research in this topic may look at specialty medical organizations, such as those involved in the Patient Centered Primary Care Collaborative (2007), and state medical societies, particularly in the states discussed with notable passage of legislation. In addition, other research may look at advocacy for scope-of-practice for other APRNs, or at responses to this form of advocacy from professional nursing organizations.

CONCLUSION

The healthcare system is adapting to changing needs in order to provide care of higher quality, access, and value for underserved populations, including the newly insured and the elderly. Defining provider roles and leadership within these models is of interest to both healthcare providers and their respective organizations. The American Medical Association's views have been shown to favor placing primary care physicians in formal leadership and management roles through strategic advocacy of legislation at the state level. As expanded scope for practice for nurse practitioners continues to be endorsed by many stakeholders in healthcare policy, it remains to be seen how successful the AMA's rhetorical strategy will be.

REFERENCES

- American Association of Nurse Practitioners (2015). State practice environment. Retrieved from <http://www.aanp.org/legislation-regulation/state-legislation-regulation/state-practice-environment>
- American Medical Association (1970). Medicine and nursing in the 1970s: A position statement. *Journal of the American Medical Association*, 213, 1881-1883.
- American Medical Association (2011). *In the General Assembly State of __: An act to support physician-led team based health care*. Retrieved from <http://aacuweb.org/aacu/issues/proactive/physicianledteams>
- American Medical Association (2012). *Best messages: Physician-led teams*. Retrieved from <http://aacuweb.org/aacu/issues/proactive/physicianledteams>
- American Medical Association (2012, November 13). AMA adopts new policies on final day of voting at interim meeting. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page>
- American Medical Association (2012, November 13). *The structure and function of interprofessional health care teams: New policies and principles adopted by the AMA House of Delegates*. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page>
- American Medical Association (2013). Physician-led health care teams. *AMA Advocacy Resource Center*. Retrieved from <http://aacuweb.org/aacu/issues/proactive/physicianledteams>
- American Medical Association (2013, April 17). This week's news: New medical home standards would leave room for nonphysician leadership. *AMAWire*. Retrieved from http://www.ama-assn.org/ams/pub/amawire/2013-april-17/2013-april-17-general_news2.shtml

American Medical Association (2013, May 15). AMA advocates for physicians' interest state by state. *AMAWire*. Retrieved from <http://www.ama-assn.org/ams/pub/amawire/2013-may-15/2013-may-15.shtml>

American Medical Association (2013, September 18). Physician-led health care teams offer high-quality care. *AMAWire*. Retrieved from <http://www.ama-assn.org/ams/pub/amawire/2013-september-18/2013-september-18.shtml>

American Medical Association, et al. (2013, October 28). Letter to Robert Petzel re: Veterans Health Affairs nursing handbook 1180.03. Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>

American Medical Association (2013, November 18). AMA passes recommendations for payment models that support new approaches to team-based health care. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/2013/2013-11-18-ama-passes-recommendation-for-payment-models.page>

American Medical Association (2014). Physician-led team based care. Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>

American Medical Association (2014, June 9). AMA adopts policy to define team-based healthcare. *AMA News Room*. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-09-policy-to-define-team-based-medical-care.page>

American Medical Association (2015). AMA mission and guiding principles. Retrieved from <http://www.ama-assn.org/ama/pub/about-ama/our-mission.page?>

American Medical Association (2015). Advocacy topics. Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/topics.page?>

- Andrus, L.H., & Fenley, M. (1975). Assistants to primary physicians in California. *Western Journal of Medicine*, 122, 80-86.
- Anonymous (2004). Collaboration and independent practice: Ongoing issues for nursing. *Nevada RNformation*, 13(4), 8-10.
- Blue Cross Blue Shield of Michigan (2014). *2014 Partners in health care report: Creating a high-performing health care system*. Retrieved from <http://www.bcbsm.com/content/dam/public/Providers/Documents/help/documents-forms/partners-report.pdf>
- Bureau of Labor Statistics (2013, December 19). Occupations with the largest number of job openings due to growth and replacement needs, 2012 and projected 2022. Retrieved from <http://www.bls.gov/news.release/ecopro.t08.htm>
- Cawley, J.F., Cawthorn, E., & Hooker, R.S. (2012). Origins of the physician assistant movement in the United States. *Journal of the American Association of Physician Assistants*, 25(12), 36-42.
- Christman, L. (1998). Advanced practice nursing: Is the physician's assistant an accident of history or a failure to act? *Nursing Outlook*, 46, 56-59.
- Collier, R. (2011). American Medical Association membership woes continue. *Canadian Medical Association Journal*, 183(11), E713-E714. doi: 10.1503/cmaj.109-3943
- Commonwealth Fund (2014, July 9). Gaining ground: Americans' health insurance coverage and access to care after the Affordable Care Act's first open enrollment period. Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/health-coverage-access-aca>
- Commonwealth Fund (2015, February 25). How will the Affordable Care Act affect the use of health care services? Retrieved from <http://www.commonwealthfund.org/publications/issue-briefs/2015/feb/how-will-aca-affect-use-health-services>

- Fairman, J. A. (1999). Playing doctor? Nurse practitioners, physicians, and the dilemma of shared practice. *The Long Term View*, 4, 27-35.
- Fairman, J.A. (2008). *Making room in the clinic: Nurse practitioners and the evolution of modern health care*. New Brunswick, NJ: Rutgers University Press.
- Ford, D.J. (1999). *The rhetoric of the angry patriarch as exemplification of ideological displacement: The rhetoric of the American Medical Association during the Clinton Health Security Act debate*. (Unpublished doctoral dissertation). The University of Kansas, Lawrence.
- Geisinger Health System (2015). About us-Geisinger. Retrieved from <http://www.geisinger.org/pages/about-geisinger/index.html>
- HB346: *Nurse practitioners; practice as part of patient care teams that includes a physician*, Virginia General Assembly 2012 Session (2012).
- Hoffman, M.F. & Cowan, R.L. (2008). The meaning of work/life: a corporate ideology of work/life balance. *Communication Quarterly*, 56(3), 227-246. doi: 10.1080/01463370802251053
- Hoffman, M.F., & Ford, D.J. (2010). *Organizational rhetoric: Situations and strategies*. Thousand Oaks, CA: SAGE Publications.
- Hoven, A.D. & MacLeod, B. (2014, April 14). Letter to the Honorable Richard Alloway, Pennsylvania State Senate. Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>
- Iglehart, J.K. (2013). Expanding the role of advanced nurse practitioners—risks and rewards. *The New England Journal of Medicine*, 368, 1935-1941. doi: 10.1056/NEJMp1301084

IHS, Inc. (2015). *The complexities of physician supply and demand: Projections from 2013 to 2025*. Washington, DC: Association of American Medical Colleges.

Institute of Medicine (2010, April). *A summary of the February 2010 forum on the future of nursing: Education*. Washington, D.C.: The National Academies Press.

Institute of Medicine (2011). *The future of nursing: Leading change, advancing health*. Washington, D.C.: The National Academies Press.

Intermountain Healthcare (2015). Mission, vision, values. Retrieved from <http://intermountainhealthcare.org/about/overview/Pages/mission.aspx>

Joint Commission (2014). Primary care medical home: Standards FAQ Details. Retrieved from http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=537&StandardsFAQChapterId=8

Kaiser Family Foundation (2013). Summary of the Affordable Care Act. Retrieved from <http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/>

Kaiser Permanente (2015). Fast facts About Kaiser Permanente. Retrieved from <http://share.kaiserpermanente.org/article/fast-facts-about-kaiser-permanente/>

Lapkin, S., Levett-Jones, T., & Gilligan, C. (2013). A systematic review of the effectiveness of interprofessional education in health professional programs. *Nurse Education Today*, 33, 90-102. doi:10.1016/j.nedt.2011.11.006

LB107: *Eliminate integrated practice agreements and provide for transition-to-practice agreements for nurse practitioners*, Legislature of Nebraska (2015).

Lynaugh, J.E. (2008). Nursing the great society: The impact of the nurse training act of 1964. *Nursing History Review*, 16, 13-28.

- Madara, J.L. (2014). American Medical Association opposition to Legislative Bill 916. Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>
- Marquis, B.L., & Huston, C.J. (2015). *Leadership roles and management functions in nursing: Theory and application (8th Ed.)*. Philadelphia: Lippincott Williams & Wilkins.
- Mayo Clinic (2015). Search results for "Physician Led Team". Retrieved on April 27, 2015 from [http://www.mayoclinic.org/search/search-results?q=physician led team](http://www.mayoclinic.org/search/search-results?q=physician+led+team)
- National Council of State Boards of Nursing (2015). Campaign for consensus. Retrieved from <https://www.ncsbn.org/738.htm>
- National Governors Association (2012). *The role of nurse practitioners in meeting increasing demand for primary care*. Retrieved from <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>
- Nuckolls, K.B. (1974). Who decides what the nurse can do? *Nursing Outlook*, 22(10), 626-631.
- Patchin, R.J. (2010, October 5). AMA responds to IOM report on future of nursing. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>
- Patient Centered Primary Care Collaborative (2007). *Joint principles of the patient centered medical home*. Retrieved from <http://www.aafp.org/dam/AAFP/documents/practice-management/pcmh/initiatives/PCMHjoint.pdf>
- Robert Graham Center (2007). *The patient centered medical home: History, seven core features, evidence, and transformational change*. Retrieved from [http://www.pcmh.ahrq.gov/sites/default/files/attachments/The Patient-Centered Medical Home.pdf](http://www.pcmh.ahrq.gov/sites/default/files/attachments/The%20Patient-Centered%20Medical%20Home.pdf)

Robert Wood Johnson Foundation (2013). *How to foster interprofessional collaboration between physicians and nurses?* Retrieved from http://www.rwjf.org/content/dam/farm/reports/program_results_reports/2013/rwjf403637

Robert Wood Johnson Foundation (2015). About us. *Future of nursing: Campaign for action*. Retrieved from <http://championnursing.org/about-us>

Rogers, M.E. (1972). Nursing: To be or not to be? *Nursing Outlook*, 20(1), 42-46.

Rousselot, L.M., Beard, S.E., & Berrey, B.H. (1971). The evolution of the physician's assistant: Brownian movement or coordinated progress. *Bulletin of the New York Academy of Medicine*, 47(12), 1473-1500.

SB406: An act relating to the practice of advanced practice registered nurses and physician assistants and the delegation of prescriptive authority by physicians to and the supervision by physicians of certain advanced practice registered nurses and physician assistants, Texas Legislature (2013).

Stack, S.J. (2013). *Report of the board of trustees: AMA performance, activities, and status in 2012*. Retrieved from <http://www.ama-assn.org/assets/meeting/2013a/a13-bot-31.pdf>

APPENDIX A: BIBLIOGRAPHY OF DOCUMENTS ANALYZED

American Medical Association (2011). *In the General Assembly State of __: An act to support physician-led team based health care*. Retrieved from

<http://aacuweb.org/aacu/issues/proactive/physicianledteams>

American Medical Association (2012). *Best messages: Physician-led teams*. Retrieved from

<http://aacuweb.org/aacu/issues/proactive/physicianledteams>

American Medical Association (2012, November 13). AMA adopts new policies on final day of voting at interim meeting. Retrieved 29 September 2014 from [http://www.ama-](http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page)

[assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page](http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page)

American Medical Association (2012, November 13). *The structure and function of interprofessional health care teams: New policies and principles adopted by the AMA House of Delegates*. Retrieved from [http://www.ama-](http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page)

[assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page](http://www.ama-assn.org/ama/pub/news/news/2012-11-13-ama-adopts-new-policies-final-day.page)

American Medical Association (2013). Physician-led health care teams. *AMA Advocacy Resource Center*. Retrieved from

<http://aacuweb.org/aacu/issues/proactive/physicianledteams>

American Medical Association (2013, April 17). This week's news: New medical home standards would leave room for nonphysician leadership. *AMAWire*. Retrieved from

http://www.ama-assn.org/ams/pub/amawire/2013-april-17/2013-april-17-general_news2.shtml

American Medical Association (2013, May 15). AMA advocates for physicians' interest state by state. *AMAWire*. Retrieved from [http://www.ama-](http://www.ama-assn.org/ams/pub/amawire/2013-may-15/2013-may-15.shtml)

[assn.org/ams/pub/amawire/2013-may-15/2013-may-15.shtml](http://www.ama-assn.org/ams/pub/amawire/2013-may-15/2013-may-15.shtml)

American Medical Association (2013, September 18). Physician-led health care teams offer high-quality care. *AMAWire*. Retrieved from [http://www.ama-](http://www.ama-assn.org/ams/pub/amawire/2013-september-18/2013-september-18.shtml)

[assn.org/ams/pub/amawire/2013-september-18/2013-september-18.shtml](http://www.ama-assn.org/ams/pub/amawire/2013-september-18/2013-september-18.shtml)

American Medical Association, et al. (2013, October 28). Letter to Robert Petzel re:

Veterans Health Affairs nursing handbook 1180.03. Retrieved from

<http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>

American Medical Association (2013, November 18). AMA passes recommendations for payment models that support new approaches to team-based health care. Retrieved

from <http://www.ama-assn.org/ama/pub/news/news/2013/2013-11-18-ama-passes-recommendation-for-payment-models.page>

American Medical Association (2014). Physician-led team based care. Retrieved from

<http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>

American Medical Association (2014, June 9). AMA adopts policy to define team-based

healthcare. *AMA News Room*. Retrieved from <http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-09-policy-to-define-team-based-medical-care.page>

Hoven, A.D. & MacLeod, B. (2014, April 14). Letter to the Honorable Richard Alloway,

Pennsylvania State Senate. Retrieved from <http://www.ama->

[assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?](http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?)

Madara, J.L. (2014). American Medical Association opposition to Legislative Bill 916.

Retrieved from <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/physician-team-based-care.page?>

Patchin, R.J. (2010, October 5). AMA responds to IOM report on future of nursing. Retrieved

from <http://www.ama-assn.org/ama/pub/news/news/nursing-future-workforce.page>

APPENDIX B: CRITICAL RESEARCH PROCESS

MEMO

DATE: October 8, 2014

TO: Geri Neuberger, PhD, RN, & KU School of Nursing Research Committee

FROM: Debbie Ford, PhD

SUBJECT: Explanation of research methodology for Erin Ekholm's Honors Project
Erin Ekholm is in the process of conducting her honors research project with me. She has submitted her abstract to be considered for presentation at the Mind & Heart Together research program and MNRS. She is conducting a rhetorical criticism of the strategies used by the American Medical Association to influence the outcome of the debate over who should be designated in legislation as the leader of the health care team. Although this methodology may be considered a very specific type of qualitative research, it is not commonly used in nursing. It is most commonly used in the disciplines of communication studies and English. Thus, I am writing this brief explanation of the critical research process in support of her application. If you have any questions about this process, I would be happy to talk with you.

The critical research process is outlined in the diagram included with this document. *Critical* in this approach refers to *critique*, rather than to the more commonly used *sense of urgency*. It is a systematic, rigorous method for deconstructing texts in order to draw conclusions about the choices a rhetor (speaker) made in achieving a goal. In this case, the rhetor is the AMA and its goal was to influence the legislative definition of health care team leader. We have not concluded yet what the AMA's specific goal was, as the analysis of the texts is still in process.

As noted in the diagram, the first step is to define a critical problem. Critical problems most often arise from an inherently interesting text (e.g., King's *I Have a Dream* speech), a problematic text (e.g., the various messages sent by BP following the explosion), a theory question (i.e., testing rhetorical theory), or a method question (i.e., testing a rhetorical-critical method, such as cluster analysis). Erin selected AMA and this debate after extensive discussions with me. It will provide important background for another study on health care team communication on which I am working. After submitting this article to the *BSN Honors Journal* as a single case study, our long-term plan is to use the results of Erin's analysis as important background work for the health care team study.

The second step is to select the texts for analysis. The four criteria upon which you choose the texts include: immediacy (the text is in front of you), distinctiveness (there is something striking about the text), representativeness (the text[s] represents a wider set of messages), and relevance. In Erin's case, we have selected the AMA's examples of texts from their website focused on this issue (health care team leadership). These are all statements to which the general public has access.

Third, the critic conducts a broad, open-ended analysis of each text (press release) individually, using multiple inconsistent categories. They are inconsistent inasmuch as

many phrases function in more than one way in a text; each of these uses would be noted in the analysis. In order to maintain consistency of analysis across texts, Erin will use the enclosed Worksheet for Identifying Rhetorical Strategies in Organizational Texts (Hoffman & Ford, 2010). She will complete one form for every text analyzed. Together we also will conduct a thematic analysis across all forms in order to identify themes and commonalities in strategies.

Fourth, Erin will conduct historical, contextual, and relevant theoretical research. In this case, she will need to conduct historical research about the development of health care professions as disciplines in the US. She will also review historical research about the organization itself in its development as a trade association. She will need to gather as much background as possible for us to understand the AMA as a rhetor who is making choices in regard to this particular issue. I will direct her to relevant theoretical research, as that will emerge based upon the sets of strategies she finds in the rhetoric. For example, if she finds a heavy reliance upon narratives (stories), she would need to develop an understanding of narrative theory. However, until the analysis of the texts is completed, it is not appropriate to conduct theoretical research in advance, as it may unnecessarily bias the critic in the analysis of the messages themselves.

Last, Erin will develop an explanation and evaluation of the AMA's strategies, developing an overarching form to answer the critical problem. This is where she explains how the rhetoric functioned, and whether the choices made were as effective as possible (to the extent a public audience can judge). Recommendations for future research, as well as recommendations to other organizations, including nursing organizations, undertaking such influence will be generated.

In summary, Erin will be following a systematic process for analyzing and drawing conclusions about the AMA's strategies. Below are several references, in case they might be helpful. If you have any questions, please do not hesitate to call or email me. Thank you for your consideration.

- Bisel, R. S., & Ford, D. J. (2008). Diagnosing pathogenic eschatology. *Communication Studies*, 59, 340-354.
- Ford, D. J. (1999). *The rhetoric of the angry patriarch: The rhetoric of the American Medical Association during the Health Security Act debate* (Unpublished doctoral dissertation). University of Kansas, Lawrence.
- Foss, S. K. (2004). *Rhetorical criticism: Exploration and practice*. Long Grove, IL: Waveland Press, Inc.
- Hoffman, M. F., & Ford, D. J. (2010). *Organizational rhetoric: Situations and strategies*. Thousand Oaks, CA: Sage.
- Rowland, R. C. (1999). *Analyzing rhetoric: A handbook for the informed citizen in a new millenium*. Dubuque, IA: Kendall/ Hunt Publishing Co.

Critical Research Process
Robert C. Rowland

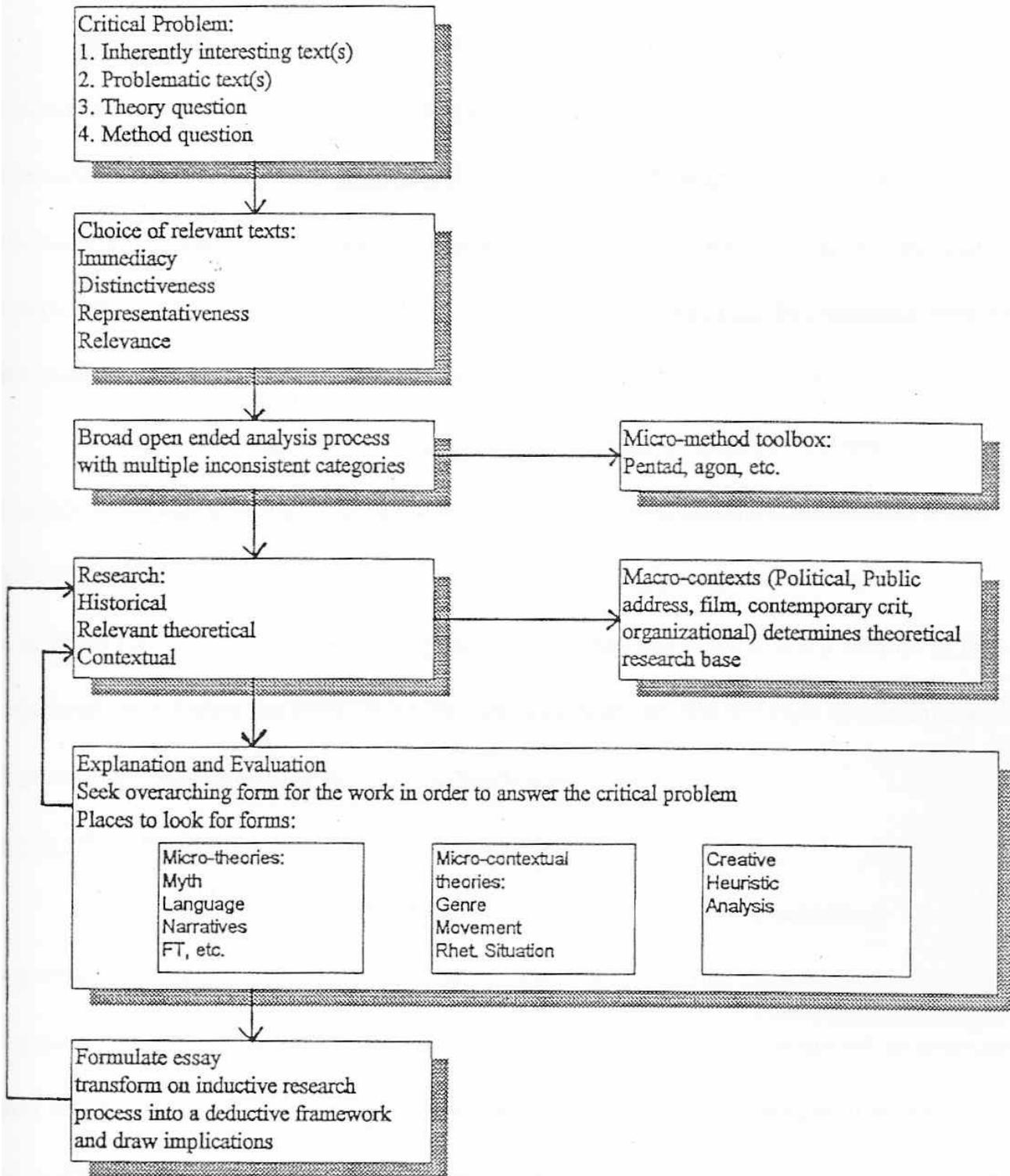


Figure 2

APPENDIX C: ANALYSIS WORKSHEET

Worksheet for Identifying Rhetorical Strategies in Organizational Texts

(From Hoffman & Ford, 2010, p. 238-239; adapted by Ford, 2013)

Text:

Source Information:

Date published or retrieved (website):

Date you analyzed the text:

What do the goals of the text appear to be?

Themes:

Requested actions:

Linguistic tone:

Role:

Who are the implied audiences (your educated guesses):

Instructions: In order to describe the rhetorical strategies in the artifact that you have selected, please identify and give examples of statements in the rhetoric that fall into the following areas.

Ethos: Appeals to Organizational Credibility

Competence:

Community:

Pathos: Appeals to Emotion

Needs: Identify the need being created or appealed to

Values: Identify the value being appealed to

Explicit appeals to values:

Demonstration of how products or services uphold values:

Discussion of philanthropic activities consistent with values:

Praise of individuals who embody values:

Identification (organizational)

Common ground:

Assumed "we":

By antithesis:

Unifying symbols:

Logos: Use of Claims & Evidence

Claims:

Evidence

Statistics:

Testimony:

Examples:

Reasoning

Inductive Reasoning [specific instance -> more general conclusion]

By example:

By analogy:

Causal reasoning:

Deductive Reasoning [general, accepted idea -> conclusion about a specific instance]

Strategies for Organizing Appeals

Introduction:

Main Body:

Conclusion:

Navigation (Web-based materials):

Stylistic Strategies

Language choices:

Visual choices:

Branding:

Strategies for Delivering Appeals

What form is the rhetoric presented in (press release, newsletter, Web site, blog, event, etc.)?

Remember to consider whether the sample of rhetoric is similar to any of the types of rhetoric that occur with regularity in organizations (identity, issue, risk, crisis, or internal). If so, also consider the specific strategy questions posted at the end of the relevant chapters.