Table. A summary meta-narrative from positive deviance and similar qualitative studies that contrast clinician styles stratified by clinical sites with positive versus other outcomes.

Setting	Positive outcomes*	Other outcomes*
Collaborative work	**Promotion, and advocacy**	
	"Passion on the part of physician leaders to continually hit that mark and for the best outcomes…"[1]	"Physician presence in championing…quality improvement efforts was weak"[1]
	"medical staff organization factors as involvement of the medical staff president with the hospital governing board, overall physician participation in hospital decision making, … are positively associated with higher quality-of-care"[2]	"[T]here's not enough physician leadership on the committee"[1] "You should remember: I don't care about any patients but mine"[3]
	Meeting	
	"**frequency of medical staff committee meetings** … are positively associated with higher quality-of-care"[2]	"It's just recently that we're able to find out which physicians are not following the guidelines… and we're finding that it's our [private] hospitalists that are more of the culprit. And those are the hardest group that we have not been able to get into a room to have conversations with…**they don't have regular meetings**."[4]
	Group decision making	
	"Physicians and non-physicians alike commented on the levelling effect of working together in the coalition, with more equitable participation and engagement among members, who grew more unified as a team. In one hospital, the coalition set a new tone for risk-taking and working on the 'leading edge', even if some ideas were not successful."[5] "Our physician champion, has been much more willing to say, 'I don't know,' and rely on other people, which is something that I don't think he necessarily did a while back."[5]	"There is still this deference to authority…we tend to put our physicians up there…'our physician said it should be, so it should be.'"[5] "Opportunities for creativity were constrained by deference to hierarchical relationships; non-physician staff yielded too readily to physicians and physicians showed limited respect for diverse expertise."[5]
Clinical work	**Receptivity to clinical suggestions**	

	"…Nurses know that they are 100% supported, all the way up to the top of the organization, that they are empowered to call rapids regardless if they're being told not to call a rapid [response]…"[6]	"…A lot of them are afraid to call the physician. So sometimes the physician would be angry that they called a rapid response…"[6] "Truthfully, I'm not going to lie. There are times where I see stuff that's wrong and I'm just like, forget it… if it's not going to hurt anybody…if it was a couple of [antibiotic] days."[4] "You know…one of them when I call, gets very angry and seems quite put out that I am talking to [them] in the first place."[4] "I gave you orders, and what are you calling me again for?"[1]
	Collaboration on clinical care	
	"Clinicians frequently discuss difficult cases to solicit the opinions and insights of their colleagues."[7]	"Providers...tended to practice without the benefit of their colleagues' opinions."[7]

Notes:

* Other outcomes include measures of team performance in the study by Hu[3] and tactics previously associated with clinical outcomes at the organizational level by Curry[5].

This file, with links to references is available at https://ebmgt.github.io/clinician_culture/ .

References

1. Curry LA, Spatz E, Cherlin E, Thompson JW, Berg D, Ting HH, Decker C, Krumholz HM, Bradley EH. What distinguishes top-performing hospitals in acute myocardial infarction mortality rates? A qualitative study. Ann Intern Med. 2011 Mar 15;154(6):384–390. PMCID: PMC4735872

2. Shortell SM, LoGerfo JP. Hospital medical staff organization and quality of care: results for myocardial infarction and appendectomy. Med Care. 1981 Oct;19(10):1041–1055. PMID: 7311636

3. Hu YY, Parker SH, Lipsitz SR, Arriaga AF, Peyre SE, Corso KA, Roth EM, Yule SJ, Greenberg CC. Surgeons' Leadership Styles and Team Behavior in the Operating Room. J Am Coll Surg. 2016 Jan;222(1):41–51. PMCID: PMC4769879

4. Vaughn VM, Krein SL, Hersh A, Buckel WR, White AT, Horowitz J, Patel PK, Gandhi TN, Petty LA, Spivak ES, Bernstein SJ, Malani AM, Johnson LB, Neetz RA, Flanders SA, Galyean P, Kimball E, Bloomquist K, Zickmund T, Zickmund SL, Szymczak JE. Excellence in Antibiotic Stewardship: A mixed methods study comparing High, Medium, and Low Performing Hospitals. Clin Infect Dis Off Publ Infect Dis Soc Am. 2023 Dec 6;ciad743. PMID: 38059532

5. Curry LA, Brault MA, Linnander EL, McNatt Z, Brewster AL, Cherlin E, Flieger SP, Ting HH, Bradley EH. Influencing organisational culture to improve hospital performance in care of patients with acute myocardial infarction: a mixed-methods intervention study. BMJ Qual Saf. 2018 Mar;27(3):207–217. PMCID: PMC5867431

6. Dukes K, Bunch JL, Chan PS, Guetterman TC, Lehrich JL, Trumpower B, Harrod M, Krein SL, Kellenberg JE, Reisinger HS, Kronick SL, Iwashyna TJ, Nallamothu BK, Girotra S. Assessment of Rapid Response Teams at Top-Performing Hospitals for In-Hospital Cardiac Arrest. JAMA Intern Med. 2019 Oct 1;179(10):1398–1405. PMCID: PMC6664378

7. Rose AJ, Petrakis BA, Callahan P, Mambourg S, Patel D, Hylek EM, Bokhour BG. Organizational characteristics of high- and low-performing anticoagulation clinics in the Veterans Health Administration. Health Serv Res. 2012 Aug;47(4):1541–1560. PMCID: PMC3401398