LEARNING OBJECTIVES

By the end of this chapter, the student will be able to:

- Distinguish between a team, a task force, and a committee;
- Compare and contrast disciplinary, interdisciplinary, and cross-functional teams;
- Describe the challenges associated with teamwork in healthcare organizations;
- Summarize current trends in the use of teams in healthcare;
- Compare and contrast the benefits and costs of teamwork;
- List key features of wicked problems;
- Identify ways to fit into a team and to select team members;
- Apply current thinking on emotions to teamwork scenarios;
- Discuss the importance of communication on teams;
- Describe strategies for managing conflict on a team; and
- Provide examples of teams in healthcare settings.

INTRODUCTION

Unless you’ve lived alone your entire life, by the time you obtain your first job in the healthcare arena, you will have been on a team. Family teams organize chores, vacations, and household projects. In school, students are assigned tasks—almost from the sandbox—that require small group work and cooperation. Extra-curricular activities—Girl Scouts, Boy Scouts, Junior Achievement, Habitat for Humanity—all require young people to work in cooperative groups. And let us not forget the soccer moms and dads, who chauffer their offspring from preschool through high school to participate in sports teams. So why does the thought of teamwork assignments make entire classes of healthcare management students cringe? Despite years of teamwork experiences, few students in any discipline are actually educated and trained in the “how-to” of working in teams. Yet in healthcare management, from the day you enter the door of your first job, your role will include being part of a team. Teamwork requires leadership, strategic thinking, diverse groups of people with different perspectives and disciplines, excellent organizational and interpersonal skills, and a good sense of humor. The purpose of this chapter is to help you understand the formation and operation of teams, the benefits and costs of teams, and tools to navigate the sometimes tricky waters of teamwork.

WHAT IS A TEAM?

Most simply, a team is a group of people, working together to achieve a common goal (Grumbach & Bodenheimer, 2004). Teams typically include individuals with complementary skills who are committed to a common approach for which they hold themselves mutually accountable (Katzenbach & Smith, 2004). The formation and operation of teams are central to the effective functioning of healthcare organizations. In healthcare organizations, teams can be composed of one or more disciplines, for example, the nursing team, the physician leader team, the management team, or the quality improvement team. In Chapter 1, you learned about the internal structure of healthcare organizations. For example, a senior Vice President has several directors who report to him, which constitutes a management team. Likewise, the administrator or CEO and all Vice Presidents that report to her comprise an executive team.

One of the distinguishing characteristics of healthcare organizations is that the professional staff needs to work closely and collaboratively to meet patient needs. In other words, the tasks of individual employees affect, and are dependent upon, the work of others. This is known as task interdependency. Because the healthcare needs of patients cut across an organization’s different disciplines or functions, it is important that interdisciplinary clinical teams be set up to ensure the delivery of safe, effective, and timely care. In addition, teams can be organized to address a short-term, quality assurance problem, such as “Why did Mrs. Jones fall out of bed?” or long-term problems, such as preventing harm to all patients in all aspects of care (Ball, 2005). (See Textbox 13-1.) Moreover, cross-functional teams (CFTs) are common in healthcare organizations to address specific organizational needs, such as service excellence, environmental sustainability and green initiatives, and clinical services marketing (Thompson, 2010). These CFTs include representatives from clinical and nonclinical areas of the organization. It is widely believed that the use of clinical and cross-functional teams will become more critical in the future as healthcare organizations become more complex and the demands for effective patient management increase (Jain, Thompson, Chaudry, McKenzie, & Schwartz 2008). (See Textbox 13-2.)

TEXTBOX 13-1. QUALITY IMPROVEMENT TEAMS IN A HOSPITAL

The West Florida Regional Medical Center established a Continuous Quality Improvement (CQI) process for its hospital in Pensacola, Florida. The purpose of the CQI process was to improve the way that services were provided to patients. The approach the hospital took was to place employees into teams of individuals that analyzed the clinical (e.g., patient care) and nonclinical processes (e.g., support services) that were in need of improvement. For example, teams were formed that examined the labor/delivery/recovery/postpartum (LDRP) services and the distribution and use of medications within the hospital. The teams critically reviewed these processes and came up with suggestions for improving quality. For LDRP, changes were identified to develop package pricing for having a baby, as well as ensuring that LDRP met the needs of consumers. The team examining the use of medications found that listing medications for physicians in order of increasing costs per average daily dose rather than alphabetically resulted in an annual savings of about $200,000. This illustrates the impact of team decision making through a CQI process on improving cost and quality of operations in a hospital.


TEXTBOX 13-2. USING CROSS-FUNCTIONAL CLINICAL TEAMS TO IMPROVE PATIENT ACTIVITIES OF DAILY LIVING

Cross-functional teams (CFTs) have been advocated as a means to ensure effective care that results in positive patient outcomes. Prior research has found that CFTs are associated with more creative solutions, better quality decisions, increased organizational effectiveness, and lower turnover.

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Mickan (2005), some of the best ways to convince a clinician that interdisciplinary teamwork is important is to show them the relationship to the benefits of effective healthcare teams. It will not always be an easy task, but in the long run, it will be rewarding. Task forces require teamwork, but don’t have the life of a committee. A blue-ribbon task force may be commissioned for several years by a professional association or institute to examine issues in healthcare services delivery, such as medical errors and patient safety (Institute of Medicine, 2001). These groups focus on a specific agenda, have a limited term of tenure, and disband when a report or book is issued. At the intra-organizational level, a quality assurance committee comprised of individuals from many departments may have people appointed to 3-year terms. At the end of that time, a person whose term has expired steps down, but the committee and the work of the committee lives on. Committees such as these usually have a person for whom this area is their full-time job, but representatives of multiple disciplines and areas of the organization are required to examine problems and to implement organizational policy decisions.

THE CHALLENGE OF TEAMWORK IN HEALTHCARE ORGANIZATIONS

Originally, hospitals grew out of religious orders, and nuns and monks provided health care to the poor. If you were wealthy, uneducated nurses tended to you at home, and physicians made house calls. Prior to the late 1700s and early 1800s, medical training was an apprenticeship, and there were no university-trained nurses. The U.S. Civil War and the Crimean War fueled the development of the nursing profession. The first nurse training school in the United States was created in 1798 at New York Hospital, by a physician. Florence Nightingale, a nurse, founded the first training school for nurses at St. Thomas Hospital in England in 1860 after the Crimean War and published her landmark book, Notes on Nursing, in 1890 (Donahue, 1985). Over time and as the field of nursing evolved, nursing education moved out of strictly hospital training programs into university-based settings (Donahue, 1985).

The American Medical Association (AMA) was formed in 1842, and its first meeting was to discuss the appalling lack of quality in U.S. medical schools and their products—physicians. The AMA Council on Medical Education was formed in 1847. Abraham Flexner, working at the Carnegie Foundation, traveled around the United States and Canada to examine the structure, processes, and outcomes of the more than 300 medical schools that existed at that time. His 1910 report, Medical Education in the United States and Canada, often referred to as “The Flexner Report,” called for dramatic reorganization in the medical education system. Those schools that were at the “A” level (such as the Johns Hopkins School of Medicine) were the standards by which all other schools were evaluated. The report recommended that “B”-level schools either get the resources to become “A”-level schools or go out of business. Flexner urged all “C”-level schools, which were considered substandard (some had no books!), to cease production of physicians (Flexner, 1910).

Compared to medicine and nursing, healthcare management is a young discipline. The University of Chicago founded the first program in health administration in 1934 under the leadership of Michael M. Davis, who had a PhD in sociology. Davis recognized that there was no formal training for hospital managers and that an interdisciplinary program of education was needed. Envisioning the role of the healthcare manager as both a business and social role, he utilized the expertise of medical, social service administration, and business faculty to create an interdisciplinary model that has been replicated repeatedly across the United States and throughout the world (University of Chicago, n.d.). Schools with a degree in healthcare management or administration were originally all master’s degrees, geared to preparing hospital administrators. Now, in addition to master’s degrees, there are baccalaureate and doctoral programs in healthcare management. More jobs in healthcare management are being created outside of hospital settings than within (Bureau of Labor Statistics, 2010). Increasing specialization of health care, burgeoning allied healthcare disciplines, a diversity of healthcare organizations, greater variety in jobs, higher expectations for healthcare outcomes, and demanding consumers mean that healthcare organizations must be able to respond appropriately, effectively, and efficiently. Interdisciplinary teams and teamwork provide the mechanism for improved responses to these demands.

Despite demonstrated need and effectiveness of interdisciplinary teams, formal educational training in this skill for physicians and nurses is rare (Baker, Salas, King, Battles, & Barach, 2005; Buchbinder et al., 2005). A poll conducted in 2004 by the American College of Physician Executives (ACPE) revealed that about one-quarter of the physician executive respondents were seeing problem physician behaviors almost weekly (Weber, 2004). Thirty-six percent of the respondents reported conflicts between physicians and staff members (including nurses), and 25% reported that physicians refused to embrace teamwork. The Institute of Medicine has recommended that healthcare organizations develop effective teams (Institute of Medicine, 2001). Physicians and nurses work from a clinical framework of advocating at the individual level for patients and families. Healthcare managers, on the other hand, are trained to look at population level and organization-wide issues. Sometimes, clinicians and managers have head-on collisions due to these contrasting worldviews (Mellin, Marshall, McElhanan, & Abbasi, 2003).

Developing teams and facilitating team activities are recognized competencies for healthcare managers (Steff, 2008). However, there is little formal preparation in teamwork in undergraduate and graduate healthcare management education programs (Legatt, 2007), and therefore, much of the manager’s understanding of team dynamics and operations is learned on the job. Developing and managing teams is a skill that you will want to build as you progress in your healthcare management career.

Healthcare executives recommend that to engage medical staff, managers need to promote alignment between hospitals and physicians. This alignment can be accomplished 291292through the use of shared goals, especially those relating to patient safety (Sherman, 2006). Understanding physicians is key to getting them on board with teamwork and reducing medical errors. Physicians are pulled in multiple directions by multiple demands, and their time is at a premium. Valuing a physician’s time means organizations must have competent team members in place to whom physicians can delegate tasks that they might otherwise have to do themselves. Promoting interdependence on trustworthy teammates is critical in achieving safe, effective patient care. As a healthcare manager, you will be responsible for working with and encouraging all healthcare professionals to become good team members. It will not always be an easy task, but in the long run, it will be rewarding.

THE BENEFITS OF EFFECTIVE HEALTHCARE TEAMS

One of the best ways to convince a clinician that interdisciplinary teamwork is important is to show them the relationship to patient care. According to Mickan (2005), some of the benefits of effective teams include improved coordination of care, efficient use of healthcare services, increased
job satisfaction among team members, and higher patient satisfaction. Ruddy and Rhee (2005) echoed these findings in their literature review of primary care for the underserved. Robin, Vogt, and Fireman (2003) demonstrated that primary healthcare teams in ambulatory care settings could improve quality of care and corporate productivity when employers were empowered to be innovative and rewarded for performance. Additional benefits of teams include sharing different areas of knowledge and expertise, learning from different perspectives, and realizing innovative ideas that come from other team members (Thompson, 2010; Quinlan & Robertson, 2010). For example, Alexander et al. (2005) found in their study of teams providing treatment to mental health patients that patients experienced greater improvements in activities of daily living when teams had higher levels of sharing and staff participation. (See Textbox 13.2.) Specialized hospital services also can benefit from “service line” team approaches that show increased trust among staff, shared goals, and greater patient satisfaction (Liedtka, Whitten, & Sorrells-Jones, 1998). (See Textbox 13.3.)

Clinical research has underscored the importance of excellence in teamwork in the operating room (OR). A multisite retrospective study of 74 Veterans Health Administration (VHA) facilities found that “participation in the VHA Medical Team Training program was associated with a lower surgical mortality rate” (Neely et al., 2010, p. 1693). By lower, the authors mean an 18% reduction in annual mortality rates. The findings from this study are significant not only in a research sense, but also in a true clinical sense: that figure represents lives saved through improved teamwork. Dissemination of this information throughout all surgical training programs in the United States will require enormous effort because surgeons often believe “they alone are responsible for patient outcomes” (Pronovost & Freischlag, 2010, p. 1721). It will take a major culture shift to move many physicians and surgeons from this solo savior mentality to the “there is no I in teamwork” approach.

Textbox 13.3. COLLABORATION OF STAFF IN A SERVICE LINE APPROACH

The existing literature suggests that collaboration should make possible simultaneous improvement in both quality and cost-effectiveness of care. Collaboration supports ongoing learning for providing good care and can assist with effective redesign of care processes. An academic medical center, with a bed capacity of 500 beds, reorganized from a traditional departmental structure to a service line approach, which included 12 service centers. The service line structure used “focused teams.” Focused teams, in contrast to functional or coordinated teams, are distinguished by the fact that non-nursing professionals report to unit or service managers rather than to a central department.

The medical center staff designed a questionnaire to assess perceptions of effectiveness of the service line model in promoting collaboration and improving care outcomes. Overall, respondents—including administrators, physicians, and nurses—indicated that the successful service line collaboration was associated with a sense of greater ownership, a high level of trust, realistic expectations, and shared goals. However, there were differences in perceptions of effectiveness of the service line approach as viewed by administrators, physicians, and nurses. This showed that staff may be at different places regarding their view of the value of service line models. For example, nurses expressed feelings of being left out of decision-making processes and believed that unrealistic expectations were placed on them. Physicians also viewed input into the decision-making process as important and expressed the need to have a clear sense of strategic direction. Outcome data, in terms of patient satisfaction, cost per case, and length of stay, remained consistent for the period of time studied. The authors note that the lack of positive change in these indicators may be due to the newness of the implementation of the service line model and the possibility that chosen measures may not be sensitive enough to capture positive outcomes associated with service line collaboration. The authors concluded that the diversity of staff perspectives and experiences with service line management models makes for significant challenges for leaders of healthcare institutions and that successful collaboration can result only when these professional differences are understood and addressed.

Source: Liedtka et al., 1998.

Clinicians are not always the reluctant team builders. Sometimes higher-level management is uncertain that teamwork is worth the effort and short-term costs. For this audience, the answer lies in the bottom line: improved communication, increased productivity, increased job satisfaction, and decreased nursing turnover (Amos, Hu, & Herrick, 2005; Institute for Healthcare Improvement, 2004). In an era when nurses are retiring faster than new ones are coming into the field, healthcare managers cannot afford to ignore the loss of nurses from the workforce (Health Resources and Services Administration 2003, 2004, 2010). As noted in Chapter 11, nursing turnover costs have been estimated to be 1.3 times the salary of a departing nurse or an average of $65,000 per lost nurse (Department for Professional Employees AFL-CIO, 2010; Jones & Gates, 2007). Multiply that by the number of nurses who quit their jobs and the costs can be in the millions of dollars for healthcare organizations.

Any strategy that improves the retention of nursing staff saves the organization the costs of using agency or traveler nurses, replacing lost nurses, and training new ones, and the loss of productivity from burdening the remaining. In a large system, like the Veterans Health Administration, High Involvement Work Systems that include teamwork can mean lower service costs in the millions of dollars (Harmon et al., 2003). Show higher-level management improvements in patient satisfaction scores, as well as the money to be saved in the long run with effective teamwork, and their approvals will follow.

The Costs of Teamwork

Despite all the benefits of teamwork noted above, there can be a downside with its associated costs. The costs of teamwork include the costs of having meetings, along with a place to meet and food and coffee; the costs of trying to arrange a time that’s convenient for most of the participants; time spent in meeting and the accompanying opportunity costs, that is, how that time might have been better spent; the hard-to-measure interpersonal costs associated with having to work with other people (such as a perceived loss of autonomy and the need for compromise, which is very hard for some persons); the development of mutually respectful behaviors and trust; the costs of risk taking associated with letting go of one’s turf; and the potential embarrassment of looking bad in a group.

In 1995, Lucente, Rea, Vorce, and Yancey reported on the impact of creating a patient-focused care delivery model. (See Textbox 13.4.) Due to the merger of two acute care facilities, the hospital decided to create a patient-focused care model and a new team organization for case management to streamline care and reduce costs. A multidisciplinary steering group developed the model, and nurse managers, physicians, and patient care technicians implemented it. The authors found that patient education and quality of care improved; overtime decreased, with a savings of $112,000; and patient satisfaction was unchanged. However, when they attempted to survey 500 employees to obtain staff satisfaction levels in 1992 and 1993, only 4 surveys were returned. The poor initial response to the staff satisfaction questionnaire could have been due to methodology—or the fact that people dislike change. Resistance to organizational change is always a potential cost in teamwork, and one that shouldn’t be readily discounted.

Textbox 13.4. USE OF TEAMS IN A “PATIENT-FOCUSED CARE MODEL” IN A COMMUNITY HOSPITAL

In 1994, Augusta Medical Center in Fishersville, Virginia, opened its new facility and instituted a redesign of its patient care delivery system. The redesign project embodied the “future care model,” which is a patient-focused care delivery system that focuses on the value for the patient through...
Wicked problems are vexing—complex, complicated, and messy (Buchbinder, 2009a). Rittel and Webber (1973, p. 160) wrote on planning, and first dubbed these “wicked problems.” Drinka and Clark (2000, p. 37) wrote about “tame versus wicked problems.” Tame problems can be defined and, while not easy, they can be solved. Wicked problems are difficult to define and not easily resolved—and sometimes can never be truly solved due to multiple layers of issues, such as we see in healthcare. Rittel and Webber (1973) described ten key features of wicked problems.

1. “There is no definitive formulation of a wicked problem.
2. Wicked problems have no stopping rule.
3. Solutions to wicked problems are not true-or-false, but good-or-bad.
4. There is no immediate and no ultimate test of a solution to a wicked problem.
5. Every solution to a wicked problem is a 'one-shot operation;' because there is no opportunity to learn by trial-and-error, every attempt counts significantly.
6. Wicked problems do not have an enumerable (or an exhaustively describable) set of potential solutions, nor is there a well-described set of permissible operations that may be incorporated into the plan.
7. Every wicked problem is essentially unique.
8. Every wicked problem can be considered to be a symptom of another problem.
9. The existence of a discrepancy representing a wicked problem can be explained in numerous ways. The choice of explanation determines the nature of the problem’s resolution.
10. The planner has no right to be wrong” (Rittel & Weber, 1973, pp. 161–166).

Most healthcare problems fall along the continuum of tame to wicked, with many levels of messiness along the way. Conklin (2008) speaks of
fragmentation as a result of vexing, wicked problems interacting with social complexity. By having only one discipline examining an issue, problems can actually be exacerbated, rather than ameliorated. When different factions stare at their pieces of the puzzle and don’t attempt to see the perspectives of others, problems are addressed in a piecemeal, not holistic, manner.

Here are some examples of wicked problems:
- An 80-year-old woman has had hip replacement surgery and used up her post-op Medicare paid days at the skilled nursing facility (SNF). Her walking has improved but is not back to pre-injury status. In her home, her bedroom is on the second floor and she has a flight of stairs to climb to get to her front door. Her only daughter lives 297298in another state and has two teenagers (one of whom is struggling with depression), and her husband just lost his job.
- A Hispanic man has sustained burns over much of his upper torso, including his arms. He is uninsured and needs extensive therapy to prevent contracture (immobilization) of his arms. Neither he nor his family members are fluent in English. They don’t understand what he needs or how to access healthcare resources to help him return to his activities of daily living (ADLs).
- A young woman who is addicted to heroin gives birth. The baby is born with low Apgar scores (a numerical score on a scale from 1 to 10, given at 1 and 5 minutes after birth; a lower score indicates a sicker newborn) and is in withdrawal. Eventually, the baby is ready for discharge. The social services department is not keen on handing the baby over to the mother, who is still using heroin. However, the mother’s mother (the baby’s grandmother) says she can take care of the baby—except grandmother arrives to pick up the infant drunk (she failed to mention that she was an alcoholic) and her husband (the grandfather) is also high when he arrives because he is addicted to prescription painkillers.

As you can see from the above examples, wicked problems cannot be solved by one person or one discipline. You need to have every involved area’s input to analyze a wicked problem, because it won’t be solved by one person—or one discipline. Because of these complexities, members of a team must be selected with care.

WHO’S ON THE TEAM?

When you first start out in healthcare management, it is unlikely that you will be able to choose your teammates. It will be your job to learn the culture of the organization and to determine how best to fit into a team. Some of the questions that you can ask when you are assigned to a team are:
- What are the goals of the team?
- How will they be measured?
- What are the short-term and long-term deadlines?
- When and where does the team meet?
- To whom do I report? (Sometimes staff members are loaned to teams, so this is an important issue to resolve.)
- What is my role on the team?
- What are my responsibilities in that role?

Good managers don’t mind if a new staff member makes a list of questions and asks for clarification and direction. Coaching, mentoring, and guiding are all part of the manager’s role, and healthcare management is a continuous learning experience. Managers do mind, however, if you don’t ask questions, and go off and do the wrong thing. Additionally, good managers want thoughtful observations from a new perspective: yours.

Over time, as you assume more responsibilities and learn the organization, you may be asked to recommend team members or to convene a team to address a specific organizational issue. Getting the right people on a team is one of the most critical tasks a healthcare manager can have. When this opportunity comes, ask for counsel and advice from your manager and your coworkers. The last thing you want to do is exclude the chairman of surgery on a team that’s addressing operating room productivity. As noted previously, real-world healthcare management problems are complex, complicated, and messy. As a healthcare manager, you will need to assess the strengths and weaknesses of each potential team member before inviting him or her onto your team. You will need to ask the following questions.

Does this person:
- Belong to an area that’s affected by the problem at hand?
- Have the knowledge, skills, and disposition to do the tasks at hand?
- Have a clearly defined role on the team?
- Have the authority to make decisions and implement recommendations?
- Follow through on assignments and tasks and meet deadlines?
- Think beyond the confines of a department or discipline?
- Work collaboratively and respectfully with other disciplines?
- Have the ability to defuse tensions and de-escalate conflict?
- Have a sense of humor?
- Have a good reputation within the organization as a team player?
- Value perceptions and ideas of others?
- See organizational goals as superseding individual goals?

One tool that is sometimes used for understanding differences in team members’ personalities is the Myers-Briggs Type Indicator (MBTI), a personality inventory based on Jung’s theory of psychological types (Rideout & Richardson, 1989). The MBTI assesses four domains and four subsets within those domains on a four-by-four grid (Wideman, 2003). On the vertical axis of this grid is the Introvert-Extrovert scale; on the horizontal axis is the Sensing-Intuitive scale. Within each of the four quadrants of this grid are two more axes—the Perceiving-Judging axis and the Thinking-Feeling axis. After taking this paper-and-pencil, self-administered inventory, the individual finds her “Myers-Briggs Type” on a large square. The types are designated by letters, so when a search firm is looking for a strong executive, they would want a “ESTJ,” someone who is “responsible, dependable, highly organized, likes to see things done correctly, tends to judge in terms of standards of operating procedures, realistic, matter-of-fact, and loyal to institutions” (Wideman, 2003, p. 11).

When building a team, you may not want everyone to be a leader. As noted in Chapter 2, you also need good followers, that is, people who are willing to bring their strengths to the group process, who may be more on the sensing, introverted, intuitive end of the axis on the MBTI, rather than the extroverted end. Wideman (2003) suggests that, while project management and teamwork are becoming mandatory in most employment settings, not everyone in the workforce population is suited, by their personality type, to function well on a team. He suggests judicious use of the MBTI to see where people fit in the leadership versus followership mode and to be cautious about who is placed on a team. Many healthcare recruiters utilize the MBTI to help them select candidates for healthcare placements. In addition, many healthcare management
professional organizations offer seminars and workshops for individuals to learn about their personality styles. The key thing to know about this popular tool is that it is one of many ways to understand healthcare team members, but it is not the only way. Oftentimes, experience and the oral history of the healthcare organization where you work is the best predictor of selecting good team members.

EMOTIONS AND TEAMWORK

Psychological researchers have known for decades that infants learn emotions through observation and mimicry of caregivers’ facial expressions (Buchbinder, 2009c). In addition, Laird and Bresler (1992) demonstrated in laboratory research that when subjects’ faces were arranged into frowns, the subjects reported feeling angry—even in the absence of any cues that would induce such emotions. Muscle memory appeared to create the mood associated with the facial expressions. Recently, neuroscientists have discovered that a cluster of premotor and parietal cells called “mirror neurons” or the “mirror neuron system” (MNS) is responsible for enabling humans to learn motor skills, language, communication, and social behaviors (Jacoponi & Depretto, 2006; Rizzolatti & Craighero, 2004; Society for Neuroscience, 2008).

According to Hatfield, Cacioppo, and Rapson (1993), people who are emotionally in tune with others can read emotions within nanoseconds of observing facial expressions. The ability to read other people’s emotions has been measured through the Emotion Contagion (EC) scale. Doherty, Orimoto, Singelis, Hatfield, and Hebb (1995) found that women and physicians scored higher on the EC scale and that there were significant correlations between self-report of “catching emotion” and “judges’ ratings of participants actual emotional reactions” (Doherty et al., 1995, p. 369).

When Totterdell, Kellett, Teuchmann, and Briner (1998) looked at the relationship between mood and work groups of community nurses, they discovered “significant associations between people’s moods and the moods of their teammates at work over time” (Totterdell et al., 1998, p. 1513). The term used by these researchers and others for why this happened was “emotional contagion.” In other words, the teammates caught each other’s moods.

To summarize:
- We are hardwired to learn emotions through mimicry and mirroring.
- Emotions are communicated in a flash—literally within nanoseconds.
- Women and people in the helping professions are more sensitive to reading emotions.
- Emotions are contagious and can spread within moments.

Kanter (2004) found that optimistic leaders focus on specific tasks ahead, rather than dwelling on past failures and negativity. Although we are experiencing challenging times in health care, leaders can moderate the impact of this volatile environment. With all the women and helping professionals in healthcare settings, the majority of employees are highly sensitive to other people’s moods. Enthusiasm, confidence, and optimism are critical to leading others. Emotionally aware team members can change an organization’s emotional environment and improve the quality of employees’ and patients’ lives by helping others to become “infected” with positive emotions (Buchbinder, 2009b).

As noted in Chapter 2, emotional intelligence (EI), the concept made famous by Daniel Goleman in the late 1990s, encompasses self-awareness, self-regulation, self-motivation, social awareness, and social skills, and within each of these areas, specific skill sets (Consortium on Research for Emotional Intelligence in Organizations, 2009; Goleman, 1998). In 2006, Goleman moved to the terminology social intelligence (SI) to separate out the last two components of EI, social awareness and social skills, and began using the term “social facility” instead of “social skills” (Goleman, 2006). These two are defined as:

“Social Awareness
- Primal empathy: Feeling with others; sensing nonverbal emotional signals.
- Attunement: Listening with full receptivity; attuning to a person.
- Empathic accuracy: Understanding another person’s thoughts, feelings, and intentions.

Social Facility
- Synchrony: Interacting smoothly at the nonverbal level.
- Self-presentation: Presenting ourselves effectively.
- Influence: Shaping the outcome of social interactions.
- Concern: Caring about others’ needs and acting accordingly.” (Goleman, 2006, p. 84)

Currently there is a controversy in the industrial-organizational psychology literature regarding the definitions, models, and measurement of EI, SI, and now, emotional social competencies (ESC). Cherniss (2010, p. 184) defined ESC as “those emotional abilities, social skills, personality traits, motivations, interests, goals, values, attachment styles, and life narratives that can contribute to (or detract from) effective performance across a variety of positions.” The bottom line is that being aware of one’s emotional and social skills and being able to effectively use them is an important ability for leaders and followers. In health care, these competencies and the ability to assess when and how to utilize these competencies are essential to good leadership and effective teamwork. Protocols such as the EI360, a 360-degree assessment of an individual’s EI, help to identify an individual’s emotional and social strengths and weaknesses (Buchbinder, 2009c). With coaching and specific behavioral goals that are applied in the workplace, healthcare managers can learn how to move to the next level of their EI, SI, and ESC abilities—and how to best apply them in the workplace.

TEAM COMMUNICATION

Frequent, positive communications improve team interactions and increase trust. Organizations that empower their employees promote employee job satisfaction. Laschinger and Finegan (2005) found that nurses who felt they had access to opportunity, honest relationships, open communication with peers and managers, and trusted their managers were more likely to be attached to their organizations and have higher job satisfaction. Similarly, it has been shown that healthcare employees who view their work unit climate as participative as opposed to authoritarian provide higher levels of customer service, commit fewer clinical errors, and express less likelihood of leaving the organization (Angermeier, Dunford, Boss, & Boss, 2009).

Dreachslin, Hunt, and Sprainer (1999) conducted research to assess how diversity affected patient-centered team communication and to improve communication and patient care. Focus groups were convened to elicit key issues and to develop recommendations. The authors concluded that
healthcare managers should facilitate open and honest dialogue between management and care production teams and within the teams themselves. The process should involve care production team members in process improvement. To improve relationships between team members and nurse managers, more training is needed, both in the clinical and relationship management arenas. Diversity training has to be part of team and leadership training. The patient-centered care model must emphasize caring for patients, as well as 360-degree feedback, where nurses and technicians evaluate each other, should be implemented for assessment, communicated to team members, and used as a management tool for continuous quality improvement.

In a classic article on management teams, Eisenhardt, Kahwajy, and Bourgeois (1997) observed teams in 12 technology companies. Much like health care today, these companies operated in a high-stakes, fast-paced environment, where today’s technology is tomorrow’s dinosaur. Teams had to be lightning fast in their responses and almost precognitive to stay ahead of the competition. The authors found that teams with minimal interpersonal conflict had the same six strategies. “Team members: worked with more, rather than less information, and debated facts; developed multiple alternatives to enrich the level of debate; shared commonly agreed upon goals; injected humor into the decision process; maintained a balanced power structure; and resolved issues without forcing consensus” (Eisenhardt et al., 1997, p. 78). By keeping the focus on the facts and not on personalities, and communicating in an open, honest, and safe forum, the teams were able to have fun and be productive.

The airline industry has become a model of how to build teams in hospitals and other healthcare organizations (Nance, 2008). Pilots are trained to be team players because a plane full of people may die if they don’t pay attention to their teammates’ observations. Crew resource management has been developed to address attitudes, change behavior, and improve performance. Sexton, Thomas, and Helmreich (2000) have applied crew resource management research to hospitals, where stakes are also high and lives depend on the smooth functioning of the healthcare team. Senior surgeons were least likely to be in favor of teamwork and flat hierarchies. Medical staff responded that teamwork was imperative, but that they were not encouraged to report safety concerns. Doctors and nurses differed widely in their opinions regarding teamwork. Almost three-quarters of surveyed intensive care physicians reported high levels of teamwork with nurses, but less than half of the nurses felt the same way. These results point to the need for a more realistic appraisal of safety concerns, improved communication between team members, and enhanced team training for healthcare professionals, in all disciplines and specialties.

METHODS OF MANAGING TEAMS OF HEALTHCARE PROFESSIONALS

Koeck (1998) observed that, while healthcare delivery demands extensive teamwork, the reality is that healthcare teams often fail due to resistance to organizational change and lack of effective leadership. Effective leadership, addressed in the second chapter of this book, is needed at every level of the healthcare organization, but especially in teamwork. Because, by definition, interdisciplinary health teams are made up of people from different fields, it’s the healthcare manager’s job to take the lead and to establish team guidelines and foster good communication. It’s the responsibility of 30304 the team leader to establish communication networks. At the first meeting, the leader should obtain names, all phone numbers, e-mail addresses, and any other ways the team members can be contacted. One of the things a team leader can do to facilitate good communication is early in the life of the team is to establish guidelines for expected behaviors, processes, and outcomes in a written document. A manager can facilitate effective team functioning within her unit by providing support for struggling teams and by allowing teams to share their successes in improving teamwork and team results (Scott, 2009).

As can be seen in Figure 13-1, Guidelines for Teamwork, the document does not have to be complicated. This tool can be used to evaluate the performance of individual members of the team, thus avoiding the social loafer or free-rider syndrome, where a member of the team does nothing but gets credit for the work done by others. Managing social loafers and other problem teammates can be the biggest part of managing a team. As an effective team leader, your job is to get the best out of each team member. Attaining top performance requires understanding who your teammates are, what they need, and the ability to build consensus, being aware that you may not have 100% agreement on every decision.

FIGURE 13-1 Guidelines for Teamwork

After introductions and establishing the purpose of the team in a written document, Maginn (1995) recommends that the team leader go around the table and ask each person his or her ideas about the problem. The leader should acknowledge each idea, recording it as the team member speaks. Be sure to wait for people to respond to the question—and to each other. Don’t interrupt, and don’t let others interrupt a person when he/she has the floor. Ask critics for ideas and suggestions, getting those negative comments out on the table so they can be addressed. Remain calm, open- minded, and nondefensive. At the end of each meeting, thank everyone for their thoughtful comments, summarizing what you thought you heard and asking for clarification.

Before the meeting ends, it’s time to ask people to do some homework. Who is willing to do what task? Will there be research needed? What process should be used for reporting to each other? Send a summary of the meeting to everyone on the team, and include a list of steps that need to
be taken before the next meeting. Communication that includes everyone is key. Establish an e-mail list and be sure all correspondence regarding the project goes through it. The more information team members have, the more buy-in and cooperation will occur.

To build trust, meet commitments and do what you say you are going to do. Bring reliable information to the team. Accurate data and demonstrated skill at your work informs the team members that you are competent—and trustworthy (Maginn, 1995). Even when team members trust each other, conflict happens. At some point in time, there will be disagreement about which choices and decisions the team should make. Maginn (1995) recommends five potential strategies for conflict resolution in teams: bargaining, problem solving, voting, research, and third-party mediation.

Bargaining is when someone says, “If you go along with me this time, I’ll back you up next time.” If the choices are equally good, then bargaining can be a good tool; if the choices aren’t equal, then it may not be a good tool. Voting is democratic, but also bears the weight of potentially taking a team to the incorrect choice. Problem solving may be the better way to go. This means taking time to answer the “what if” scenarios of each alternative. “If we do this, then that might happen?” How will you assess if it’s the right option? You may not know until you try it. Doing more research is safe, but you may have time pressures that preclude the team from doing an in-depth study. When all else fails, third-party mediation is probably a win-win, especially if the third party is the boss. Often times, the team presentation to the boss will include choices that have been laid out, like a menu, for an upper-level manager to select. The alternatives are listed, the pros and cons of each alternative are provided, and the assessment plan for each alternative is in place. You win, your team wins, and your organization wins.

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CONCLUSION

This chapter has described what a team is and some of the challenges associated with teamwork in healthcare organizations. Some current trends in using teams and the benefits of teamwork, as well as costs, have been described. Tame and wicked problems were defined and related to the need for interdisciplinary teams to solve them. Fitting into teams and selecting team members were discussed, along with the Myers-Briggs Type Indicator personality inventory. The importance of emotional contagion, emotional and social intelligence, and emotional and social competencies was discussed in relation to effective teamwork. In addition, communication on teams and some methods of managing teams of healthcare professionals have been reviewed. And, finally, some examples of teams in healthcare settings have been presented. You have the background and tools; now you can begin to build your team.

DISCUSSION QUESTIONS

1. What are the differences between a team, a task force, and a committee? What are some of the potential differences in dynamics between people in these different groups?

2. Compare and contrast disciplinary, interdisciplinary, and cross-functional teams.

3. What are some of the unique challenges associated with teamwork in health care? Describe three benefits and three costs of teamwork in healthcare organizations.

4. After working in a hospital for 6 months, you have been selected to head up the team to conduct hand-washing audits on all the nursing units. Whom do you want on your team and why?

5. A member of the hand-washing audit team comes to you and complains that another team member is not pulling her weight. This individual is not your employee, but she is on your team. What should you do?

6. Define and give an example of a wicked problem in a healthcare setting.

7. List and describe five potential strategies for conflict resolution in teams. Which method is likely to be most successful if your manager likes to be involved in every decision?

8. What are the five stages of team development? Describe each stage and how that might appear in a healthcare setting.

9. What is the Myers-Briggs Type Indicator personality inventory, and why is it a useful tool for healthcare executives?

10. Over the past month, every member of the Intravenous (IV) Therapy Team has complained to you about the IV Team supervisor. Her direct reports, all RNs, agree that she is technically superb. However, their comments include statements that she is “hyper-critical,” “demeaning,” and that they “feel bad” about coming to work. It would be extremely difficult to find a replacement for this supervisor; however, if you don’t do something, it looks as if the entire IV Team will resign. What should you do?

Cases in Chapter 17 that are related to this chapter include:

Seaside Convalescent Care Center—see p. 422
REFERENCES


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