PART I

Team and Group Development

"When sufficient numbers of organization members become more self-aware, more concerned about the needs of others and more effective as group members and group leaders—they cannot help but eventually have a positive influence on the total function and structure of any system."

Shaffer and Galinsky, 1989, p. 192

CHAPTER 1

Groups-Teams-Systems

Learning Objectives

1. Understand groups as complex, open systems.
2. Apply the concept of open systems to healthcare teams.
3. Differentiate groups and teams.
4. Describe levels of systems and how they relate to healthcare teams.
5. Recognize how the diversity inherent to interprofessional healthcare teams contributes to their adaptability and sustainability.

Why Groups?

Humans are wired to be interdependent. We bond together in families, friendship groups, neighborhoods, work groups, and recently in electronic social networks like Facebook and Twitter. The world has become more complex, and the exponential growth of information that is required to solve problems is not the purview of a single person or a single profession. By recognizing our need to join with others to meet challenges, we have the opportunity for collective wisdom to emerge and facilitate the creation of new connections and innovative strategies to ensure the health and stability of the world that we share (Briskin, Erickson, Ott, & Callanan, 2009). Groups and teams have been and will

continue to be an essential part of our daily lives. Nowhere is the need for teamwork more relevant than in the healthcare arena.

Diagnosis and intervention require the efforts of a cadre of physician specialists, nurses, therapists, pharmacists, social services personnel, laboratory personnel, information managers, dietitians, transportation workers, home health aides, family caregivers, and patients. Quality health care that is accessible and cost effective requires that the boundaries between these stakeholders are made permeable through consistent collaboration (Grant & Finocchio, 1995). Skills in team building, team membership, and the understanding of group dynamics are foundational and indispensable for the next generation of healthcare leaders. Well-functioning healthcare teams are linked to good morale, reduced staff turnover, and positive patient outcomes (Gittell, 2009; Lawrence, 2002; Torrens, 2010; Woltmann et al., 2008).

CASE STORY: *The Importance of Interprofessional Teams*

At our organization, everything is a committee decision. You can have input from multiple perspectives such as nursing, social work, occupational therapy, physical therapy, and dietary. Elder problems are highly complicated. Getting other perspectives is helpful. For example, let's say you can't transport Mrs. X into the center because she keeps hitting people and is not putting her seatbelt on. What do you do? You need to get different perspectives in order to make a decision. It is like that example of the blind men and the elephant. No single perspective will describe the elephant and there probably is not one single resolution. This requires that team members are confident in what they know, amenable to listen to someone else's ideas, and willing to offer their own ideas.

—Karen J. Nichols, MD, Chief Medical Officer for VIP Plans at AmeriHealth Caritas

What Distinguishes a Group from a Random Collection of People?

There is a unique designation for each of the myriad groupings in the animal kingdom such as school (fish), troop (baboons), murder (crows), gam (whales), and group (humans). No matter what the species, the critical element that is common to all the groupings is that the individual members are interdependent. In the case of humans, "members

are linked together in a web of interpersonal relationships. Thus, a group is defined as two or more individuals who are connected to one another by social relationships" (Forsyth, 2006, pp. 2–3). Alderfer (1977) expanded the definition of human groups to include how they are distinguished from and perceived by nonmembers and how they relate to other groups. For the purposes of this text, in order for a group to be distinguished from a random collection of people, its members must have common interests and goals and regular patterns of interaction, exert influence among the members, and work interdependently to achieve goals (Cartright & Zander, 1968; Lewin, 1948; Smith, 2008).

What Is the Difference Between a Team and a Group?

The terms *team* and *group* are often used interchangeably. However, making the distinction between these two terms can offer valuable insight into how groups work and can facilitate leadership and full participation in productive teams. The term *group* comes from the French word *groupe* and the Italian *gruppo*, which were borrowed originally from the prehistoric Germanic *kruppaz* and is translated into a "round mass, lump" (Online Etymology Dictionary, 2011). The term *group* is defined by Merriam Webster (Definition of Group, 2011) as "a number of individuals assembled together or having some unifying relationship." *Team* is defined as a group that engages in more focused intentional action. The word is derived from the Middle English term *teme* and the Old English *tēon,* which is to draw or pull (Definition of Team, 2011). Katzenbach and Smith (1993) describe a team as "a small number of people with complementary skills who are committed to a common purpose, set of performance goals, and approach for which they hold themselves mutually accountable" (p. 112).

The difference between a group and a team can be described on a continuum (**Figure 1-1**). At one end of the spectrum, group refers to people with something in common and at the other end, team refers

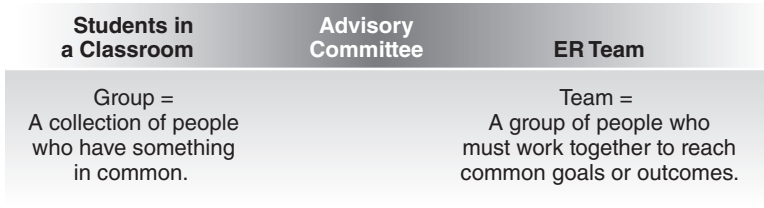

FIGURE 1-1 Group-team continuum.

REFLECTION: *Identification of Groups*

Rank in order the descriptions below with 1 being the most grouplike and 10 the least grouplike. Give reasons for your rankings.

_____ The spectators at a college football game
_____ Two strangers exchanging meaningful looks across a crowded bar
_____ A secretary conversing with the boss by telephone
_____ Five students at a university working together on a classroom assignment
_____ A mob of rioters burning stores in the inner city
_____ Thirteen inmates talking and lifting weights in a jail's exercise yard
_____ A committee deciding the best way to handle a production problem
_____ Six employees working on an assembly line
_____ An aggregate of individuals waiting in silence for a bus
_____ The Smith family of Richmond, Virginia (Mr. Smith, Mrs. Smith, and their daughter Jane Smith)

to people who must work together to get to a common agreed-upon goal or outcome. In this text, the term *group* will be used in discussions regarding the dynamics, processes, and patterns found in human collectives. Health professionals who are working together to achieve positive patient outcomes will be designated as *teams*.

A Systems Approach to Groups

Systems theory conceptualizes all physical and social systems as integrated wholes as opposed to agglomerations of disparate pieces. The 18th-century German philosopher Hegel introduced systems theory by suggesting that the whole is more than the sum of its parts: the whole determines the nature of the parts and the parts are dynamically interrelated and cannot be understood in isolation from the whole. The biologist Ludwig von Bertanffly proposed that all biological systems are open to each other and each identifiable component is related to other parts (Banathy & Jenlink, 2004). From a systems theory perspective, an individual member of a team cannot fully be understood in isolation from the team, and a team cannot be fully understood without understanding the organizational context within which it exists.

Katz and Kahn (1978) explored the systems theory further when they proposed a method to analyze open (living) social systems. They

posited that the interactive paradigm of analyzing living systems like organizations is based on continual cycles of input, throughput (processing), and outputs. All living organisms, like healthcare organizations and the groups that comprise them, are fully open systems. There are some key characteristics of open systems that resonate in the healthcare arena. Information provided by hospital staff, care recipients, suppliers, and funding sources is an example of input. Intervention from health professionals is an example of throughput, while patient outcomes, patient satisfaction rates, and quality improvement outcomes are examples of system outputs (Meyer & O'Brien-Pallas, 2010).

Health care organizations can be described as complex, adaptive systems because of the non-linear and often unpredictable nature of the interactions between the many microsystems that comprise the larger system (Sturmberg & Martin, 2013). Suchman, Sluyter, and Williamson (2011) provide an apt metaphor for healthcare organizations that is consistent with the description of complex, open systems as non-linear, open to the environment, self-organizing, and evolving (Sturmberg & Martin, 2013).

> We can perceive a healthcare organization as a gigantic complicated conversation involving its staff, patients (and their families), payers, regulators, neighbors, competitors, and anyone else who interacts with or is affected by it. Within this gigantic conversation, there are . . . myriad [simultaneous] sub-conversations . . . board meetings. . . . chance conversations at the water cooler . . . face-to-face or in virtual space . . . in the language of spoken or written words or of symbolic gestures . . . between individuals or in the private space of each person's thinking. . . . Thinking of an organization as a conversation rather than a machine . . . [we] understand that we can influence but not control what goes on, and that we do so more by the way in which we participate than by the plans we make (p. 15–16).

Each participant in a team takes in the ideas and opinions of others (input), processes this input and compares and integrates it with their most current thoughts (throughput), and together with the group, creates a new, collective perspective (output) (**Figure 1-2**). The organizational conversations reflect the organization's values, mission, culture, knowledge base, and interactive patterns among the microsystems/groups that comprise the larger organization. Organizations that attempt to impose a mechanistic, linear orientation upon an inherently open system such as a group, organization, or community discount the value

FIGURE 1-2 Conversations allow us to inquire, exchange and process information, expand thinking, and negotiate and transform that information into a common perspective that is different than the sum of its parts.

and challenges of randomness. These tightly coupled systems find themselves too rigid to respond to internal or external signals for the need to change. For example, in a hierarchical healthcare system, team members are less likely to question designated leaders and are often unwilling or unable to be professionally assertive. As a result, the repertoire of solutions to problems may be limited and the team may be ill equipped to respond to change. Change in open systems is inevitable, and adapting to these environmental changes is a continuous process. The manner in which groups and their parent organizations respond to change determines the possibilities for or limits to creativity, productivity, and outcomes (Sturmberg & Martin, 2013; Vickers, 1983; Weick, 1976).

Systems, subsystems, and the environment, are complex, interactive, and interdependent. The dynamic relationship between structure and function of all aspects of the system and its environment render the boundaries permeable and changes at any level of a system affect all other levels of the system. For instance, organizational culture is as much a product of individual behaviors as it is a facilitator of individual behaviors (Studer, 2003). The mood of an individual leader can impact the

mood of the team and be impacted by the tone of the team, or a team's effectiveness or ineffectiveness can impact and be impacted by the success of an organization. Nembhard & Edmondson (2006) found that inclusive behavior on the part of physician leaders yielded higher perceptions of psychological safety, increased engagement in all members of the healthcare team, and concomitant positive quality improvement efforts. Healthcare organizations that have been able to institutionalize relationship building as a means for integrating myriad systems consistently report higher staff retention rates and better clinical outcomes (Gittell, 2009; Singh, 2000; Woltmann et al., 2008).

Within all living systems, the balance between energy consumption (entropy) and energy infusion (negentropy) is necessary for the maintenance of a steady state for optimal systems functioning (homeostasis). An example of this in healthcare practice is the effect of caretaker rest (energy infusion) on patient care (indicates status of system's functioning). The relationship between decreased caretaker rest and decreased cognitive and clinical performance on the part of the caretaker and concomitant medical errors has been well documented (Reed, Fletcher, & Arora, 2010).

The evolutionary capacity of a system depends on flexible and adaptable patterns of organization that facilitate its ability to deal with environmental challenges and opportunities. The most agile, adaptable, and successful healthcare teams are those that are able to routinely evaluate who needs to be present and who has the most cogent information or expertise. Diverse perspectives and a broad range of information is essential for sound clinical decision-making (Briskin et al., 2009; Wheatley, 2005). Inclusionary practices such as incorporating caregivers and support personnel into the healthcare team and giving equal attention to each team member's contribution broaden the perspective of the team. In addition, psychological safety and willingness of members to share information facilitates the generation of innovative solutions for improved patient care (Meyer & O'Brien-Pallas, 2010; Nembhard & Edmondson, 2006).

Applying Systems Theory

When attempting to study, understand, and effect change in a complex social system, it is helpful to distinguish between the individual, interpersonal, group, organizational, and community levels of the system.

Individual: One person.
Interpersonal: Two individuals interacting.

Group: Three or more individuals working toward a common goal or purpose.

Organization: A social structure, often made up of groups, that pursues a collective goal to deliver some product or service.

Community: Anything beyond the organizational level. This includes other organizations, governments, or global social networks.

Systematic analysis and intervention in complex organizations takes the entire system into account (Rojas-Smith, Ashok, & Morss-Dy, 2014). Each interprofessional care team, department, or group can be considered a microsystem and can be examined with regard to its purpose, patients, professionals, processes, and patterns that distinguish it from and link it within the larger system. High-performing microsystems are characterized by inclusive leaders, strong organizational support, ongoing staff development, cohesive teams, patient/community focus, evidence-based practice, process improvement, and technology-enhanced communication through a variety of formal and informal channels (Barach & Johnson, 2006).

Successful change agents, whether they are leaders or members of groups, learn to differentiate between systems levels, shift attention from one level to another, and make an informed decision about the best level at which to intervene based on a realistic appraisal of the change agent's sphere of influence (Gillette & McCollom, 1990; Wells, 1995). Sturmber and Martin (2013) contend that intervention in complex systems is most effective when problem solvers consider the system from a variety of perspectives, frequently test hypotheses, engage in structured problem solving, practice self-reflection, and consider goals in light of their effects on the whole system. While the primary focus of this text is the group level of system, individual and interpersonal levels will also be explored. **Table 1-1** shows examples of intervention methods that are commonly used at various system levels.

Our current healthcare system is one that is complex and changing rapidly. It can been described as volatile, uncertain, complex, and ambiguous or VUCA. VUCA is a concept that was originally developed by the military and has since been applied to the rapidly evolving healthcare environment. Using a systems perspective helps to address the challenges of a VUCA world by engaging all stakeholders in conversations that will leverage their expertise and resources, broaden and strengthen relationships among stakeholders, engender creative problem solving, and inspire the diffusion of new ideas and practices (Sturmberg & Martin, 2013; Lindberg, Hatch, Mohl, Arce, & Ciemins, 2013).

TABLE 1-1 Intervention at Each Level of System

Level	Focus	Goal	Methods
Individual	Individual's behavior, perceptions, and emotions.	Increase self-awareness and self-management.	Coaching, training, mentoring, and feedback.
Interpersonal	The relationship and communication between two people.	Clarify the nature of the relationship and goals and strengthen foundations for clear communication.	Conflict management, mediation, communication, and conflict resolution training.
Group	Group goals, tasks, roles.	Clarify the nature of individual contributions, the group's purpose, and group behaviors that will foster accomplishment of goals.	Education and feedback on the stages of group development, team building, leadership, and coaching behaviors that contribute to team effectiveness and productivity.
Organization	Culture, leadership development, and organizational strategy and structure.	Increase awareness of the people in the organization that the whole is different from the sum of its parts. Identify what attributes, behaviors, and strategies are necessary in order to reach the organizational goals.	Analysis of organizational state including culture, training in culture change, top team development, and executive coaching. Identify organizational strengths in order to leverage culture change, appreciative inquiry, and dynamic inquiry.
Community	Finding common ground so that the community can be served.	Building partnerships and collaborations across communities to deliver services.	Strategic planning, community development, and futuring.

CASE STUDY: SYSTEM LEVEL INTERVENTION

The chair of the pediatrics department in a large health system, Dr. Clarice Barna, was struggling with a problem. Three of the 75 residents asked for a meeting with her. During the meeting the residents complained that they were getting inconsistent instruction from the faculty and not getting the feedback and one-on-one attention from the faculty they felt they deserved. They also felt that the nurses often gave them different instructions than the ones they got from the faculty about patient care. Although three residents were in the meeting, almost all of the talking was done by one resident, Jason.

Dr. Barna set up a meeting with the faculty and shared Jason's feedback on behalf of the residents. The faculty discussed ways to improve instruction and thought that it would be good to get additional feedback from the nurses. The faculty expressed frustration that the residents, although great students, seemed to get confused when trying to grasp that there can be more than one way to do a procedure. Each of the faculty had unique perspectives and practices they wanted to offer the residents and felt the residents needed to understand and accept multiple methods for procedures.

Dr. Barna then discussed the situation with the nursing team that worked most often with the residents. The nurses said they really enjoyed working with the residents and that they were really a top-notch group. The head nurse, Eileen Fenway, upon hearing that Jason was the student who brought this up, reminded the chair that Jason completed his internship at University Children's Hospital where the interns were each assigned a specific mentor, coach, and technical instructor in addition to faculty. She suggested that Jason's perception and expectations needed to be addressed.

QUESTIONS:

1. Look at the row labeled "Individual" in Table 1-1. Assume that Jason is the individual. Describe how Dr. Barna could improve things by talking only to Jason.
2. Look at the row labeled "Group" in Table 1-1. Describe how Dr. Barna could engage the group of faculty and nurses to help achieve the goals of improving resident education based on the feedback given by the residents.

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