CHAPTER 3

Team Building Blocks: Norms, Goals, Roles, Communication, Leaders, and Members

Learning Objectives

1. Explore how personality, environment, goals, roles, and communication impact group development.
2. Differentiate personal and group needs.
3. Recognize how norms shape team behavior.
4. Understand the value of giving and receiving feedback.
5. Match communication style to the needs of the listener.

Norms

Group norms are agreed-upon standards of behavior. Norms are the shared explicit or implicit rules that a group uses to identify standards of performance and distinguish appropriate from inappropriate behavior. When group norms are explicit or made explicit, they are commonly referred to as ground rules, agreements, group charters, conditions, or guidelines. However, not all norms are explicit, and the perceptions and

concomitant behavior of individuals in groups is profoundly—and often unconsciously—affected by social influence (Sherif, 1936).

In many progressive organizations, errors are considered teaching moments that provide opportunities for open discussion, team-based problem solving, and continuous improvement. In health care, the dire consequences of medical mistakes tend to discourage the very discussions of errors that are necessary to prevent their occurrence (O'Daniel & Rosenstein, 2008). This tendency, in combination with differing professional identities, cultures, skills, domains of concern, differences in power, capacity, resources, goals, and accountability actually requires that more attention be paid to constructing organization-wide standards and small group norms that encourage and reward dialogue and learning from errors. In groups where intraprofessional and interpersonal conflict avoidance is the norm, the ensuing misunderstandings and mistrust tend to limit collaborative or cooperative behavior. The acceptance of professional differences and the proactive examination of errors help to create opportunities for increased communication, understanding, and trust, and pave the way for collaborative endeavors between disciplines and shared ownership of team outcomes (Doucet, Larouche, & Melchin, 2001; Ratcheva, 2009).

Sustainable collaborative environments for interprofessional healthcare teams require a collectively constructed core of prescriptive (dos) and proscriptive (don'ts) group norms or ground rules that encourage interaction at intrapersonal, interpersonal, and systems levels (Nash, 2008). The Mayo Clinic's consistent adherence to norms that highlight patient-centered care and the value of teamwork has helped it retain its reputation as the most preferred provider of health care in the United States since the 19th century. At the Mayo Clinic, the contributions of receptionists, information managers, housekeeping personnel, therapists, nurses, physicians, pharmacists, food service, and

REFLECTION: *Explicit and Implicit Norms in a Group*

Identify the norms or rules of your work group.
Interview members of your group and ask them to identify the rules of your group.
How does your response differ from your coworkers? How is it the same?
How does the similarity/difference of perception affect the group's functioning?

transportation workers are all valued as an integral parts of the patient experience (Seltman & Berry, 2013). Reinforcing the norm of the centrality of patient-centered care will help team members understand that the norms and group goals take priority over personal goals and wishes.

Goals

Group goals, like norms, are both explicit and implicit. Implicit goals address the developmental processes inherent to group maturation. Focusing on, defining, and committing to the explicit work-related goals of a group is a major key to success. Commonly held goals and the collective efficacy that the achievements of these goals engender are key contributors to group performance (Silver & Bufanio, 1996). Not surprisingly, the ease of goal attainment is related to the level of goal complexity.

In the current healthcare climate, team goals for professionals are complex and require problem solving using multiple types of data and a convergence of multiple areas of expertise and skill sets. To add to that complexity, interdisciplinary team members bring diverse professional values, individual personal goals, and goals influenced by multiple reporting relationships. It is essential that goals are not only clear but constantly revisited.

Groups that continually communicate and become more explicit with regard to the teams goals are more successful in performance. Regardless of the complexities of the team tasks and team membership, if group members are committed to the group goals, the team can succeed. If the commitment to the goals is low then there is little chance of success (Locke, Latham, & Erez, 1988; Seltman & Berry, 2013).

Roles

The inherent diversity of individual personality styles makes team members' interaction and relationships key factors in team dynamics. Researchers have studied groups of people who have a variety of styles in order to ascertain whether a particular combination of member styles has any impact on group effectiveness, outcomes, and development. Lewin (1943) observed that behavior is a function of the person and the environment, or $B = f(P, E)$. Role assumption in groups is a consequence of both an individual's personality and the context of the complex system of group dynamics that comprises team behavior and effectiveness.

Roles are not necessarily attached to any individual but are assumed in response to the group's developmental needs.

Wheelan (2005) identifies three primary roles that group members assume regardless of their personality types. Task roles are needed to facilitate a project from inception to completion. Socioemotional or maintenance roles contribute to positive atmosphere of the group and foster cohesion. Organizational roles like the leader, recorder, or project manager keep the group organized. Benne and Sheats (1948) classify the functional roles of group members as task, social emotional/maintenance, and individual. Individual roles tend to disrupt group progress and weaken cohesion. **Table 3-1** provides examples of each role.

Belbin (2010) studied teamwork and observed that people in teams tend to assume various team roles, which alternate in their dominance depending upon the developmental stage of the group's activities. The nine roles where categorized into the following three groups: Action oriented, people oriented, and thought oriented. The action-oriented group includes shaper (SH), implementer (IMP), and completer–finisher (CF) roles. The people-oriented group includes coordinator (CO), team worker (TW), and resource investigator (RI) roles. The thought-oriented group includes plant (PL), monitor–evaluator (ME), and specialist (SP) roles. Each team role is associated with typical behavioral and interpersonal strengths and weaknesses. Belbin identifies the latter as "allowable weaknesses"—areas to be aware of and potentially improve upon (**Table 3-2**).

A group that is composed of members who assume only those roles related to job completion while ignoring the roles that engage and

TABLE 3-1 Benne and Sheats's Group Member Roles

Task	Socioemotional/Maintenance	Individual
Initiator/contributor	Encourager	Aggressor
Information seeker/giver	Harmonizer	Blocker
Coordinator	Compromiser	Disrupter
Evaluator	Includer	Dominator
Energizer	Follower	
Procedural technician		

Data from Benne, K. & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues*, 4(2), 41–49.

TABLE 3-2 Belbin's Team Roles

Team Role	Contribution	Allowable Weakness
	Thought Oriented (TO)	
Plant	• Creative, imaginative, unorthodox • Solves difficult problems	• Ignores incidentals • Too preoccupied to communicate effectively
Monitor Evaluator	• Sober, strategic, and discerning • Sees all positions • Judges accurately	• Lacks drive and ability to inspire others
Specialist	• Single minded, self-starting, dedicated • Provides knowledge and skills in rare supply	• Contributes on only a narrow front • Dwells on technicalities
	Action Oriented (AO)	
Shaper	• Challenging, dynamic • Thrives on pressure • Has the drive and courage to overcome obstacles	• Prone to provocation • Offends people's feelings
Implementer	• Disciplined, reliable, conservative, and efficient • Turns ideas into practical actions	• Somewhat inflexible • Slow to respond to new possibilities
Completer/ Finisher	• Painstaking, conscientious, anxious • Searches out errors and omissions • Polishes and perfects	• Inclined to worry unduly • Reluctant to delegate
	People Oriented (PO)	
Team Worker	• Cooperative, mild, perceptive, and diplomatic • Listens • Builds, averts friction	• Indecisive in crunch situations

(*continues*)

TABLE 3-2 Belbin's Team Roles (*continued*)

Team Role	Contribution	Allowable Weakness
Resource Investigator	• Extrovert, enthusiastic, and communicative • Explores opportunities • Develops contacts	• Overly optimistic • Loses interest once initial enthusiasm has passed
Coordinator	• Mature, confident; a good chairperson • Clarifies goals, promotes decision-making • Delegates well	• Can be seen as manipulative • Offloads personal work

Reproduced with permission of Belbin Associates, www.belbin.com.

facilitate member participation runs the risk of diminished cohesion, unmanaged conflict, and apathy. All of these negatively affect the sustainability of good performance and successful outcomes. Groups that are stymied in a quagmire of conflicting emotions or that are burdened with members who are myopically focused on their personal agenda will never get any work done. These scenarios can negatively impact healthcare teams who routinely deal with issues related to complex medical decision-making and the resultant interventions that will impact a patient's lifestyle and quality of life. Throughout the life of every group of health professionals, leaders and members must be alert enough to recognize what roles need to be assumed and to be flexible enough to assume the roles that will sustain optimum group functioning and consistently positive patient outcomes.

The attempt to carry out group roles as described is further complicated by the many other personal and professional roles that are held by members of healthcare teams. While a primary challenge for all team members is to separate personal needs and roles from the team needs and roles, healthcare professionals must also juggle team and discipline-related roles that often conflict at the intraprofessional and interprofessional levels. Perceived roles and responsibilities may diverge based on variations in professional socialization, experience, and organizational expectations. Some professionals—often from the same discipline—may see themselves as primarily responsible for the physiology of care while others believe they need to incorporate the contextual aspects of the illness experience in their treatment planning (Doucet et al., 2001). When faced with budget restrictions in a rehabilitation department,

does the physical therapist on the team focus her energy on advocating for the physical therapy equipment budget or facilitating a group discussion regarding prioritizing the needs of the department? The answer depends on how group, member, and contextual issues are negotiated. Each member of the healthcare team is faced with similar decisions about role choices. These choices will affect the culture, development, and performance of the team and ultimately determine the nature of patient outcomes (Freshman, Rubino, & Chassiakos, 2010).

Communication Styles

In spite of the role differentiation that exists among the disciplines, holistic approaches to health care can engender role overlap, ambiguity, and boundary management challenges (Gray, 2008; Klein, 2010; Nash, 2008). Teams that leverage common ground as well as disciplinary differences through well-constructed and maintained communication strategies are likely to demonstrate sustained high performance and achieve positive patient outcomes (Drinka & Clark, 2000; Gittell, 2009). The most successful teams, whether in face-to-face or online environments, are characterized by members who are sensitive to the orientation of others and communicate often and equitably (Wooley, Malone, Chabris, 2015).

The first step in productive communication is to get the attention of the person with whom one is trying to communicate. Team members who understand that communication styles often reflect learning styles and professional orientation will be most successful if they take the time to adjust their communication style to complement the styles of the people with whom they are communicating. People who are action oriented are interested and tend to talk about objectives, results, performance, and productivity. Strategies, organization, and facts tend to pique the attention of those who are process oriented. People who are idea oriented are interested in concept development and innovation, while those with a people orientation focus their communication on values, beliefs, and relationship building (Youker, 1996).

While the previous examples give an indication of *how* communication is carried out and received, the following model provides some insight into *what* is communicated. Conscious attention to *how* and *what* is communicated allows for more mindful, strategic, and effective communication in teams.

The Johari window (Luft & Ingham, 1950) is a classic model for identifying and improving an individual's relationship with a group and/or a group's relationships with other groups. While the discussion that

follows addresses the model from an individual perspective, the concepts are applicable to groups as individual entities within organizations, where *others* refers to other groups.

The model is represented as a square that is divided into four window panes or perspectives as shown in **Figure 3-1** and is arranged as follows:

Quadrant 1: Open/free area—what is known by the individual person and also known by others
Quadrant 2: Blind area—what is known by others but unknown to the individual
Quadrant 3: Hidden area—what is known by the individual and consciously hidden from others
Quadrant 4: Unknown area—what is unknown to both the individual and others

The panes/areas expand and contract to reflect the proportion of individual or group knowledge about an area. In newly formed groups, for instance, the open area is small since newly assembled groups of people know relatively little about one another. As groups mature, the open area increases as more information is shared and more cooperation and collaboration ensue. If open areas remain diminished, the group may be vulnerable to misunderstanding, mistrust, and confusion, and delay progress toward maturity. The ultimate goal for team members is to increase the size of the open area and decrease the size of the other areas through positive communication. The blind area is also known as the "bad breath

FIGURE 3-1 The Johari window.

Adapted from Luft, J., Ingham, H. (1950). The Johari window, a graphic model of interpersonal awareness. *Proceedings of the Western Training Laboratory in group development*. Los Angeles, CA: UCLA.

area" because an individual is unaware of something that is known by everyone else. In the case of an individual, this could be a habit such as constantly glancing at a cell phone during a meeting—unaware that the other members of the group perceive this as disrespectful. Asking for and providing constructive feedback reduces this area.

While it is appropriate to use discretion when disclosing personal or private information, feelings and information related to work proves only be helpful if they are allowed into the open area. The process of disclosure—exposing relevant information and feelings—reduces the hidden area and further expands the open area. So a group member might disclose that he/she feels disrespected when someone is checking a cell phone during a meeting or conversation. The unknown area contains information such as unconscious needs, motivations, or inherent abilities that are unrecognized by the individual or the group (**Figure 3-2**). By examining the unknown area, individuals begin to understand that perceptions of present situations may be rooted in past experiences and the insecurity or anger that may have been experienced during a difficult childhood may be a hot button that is easily triggered by a difficult interaction in the present.

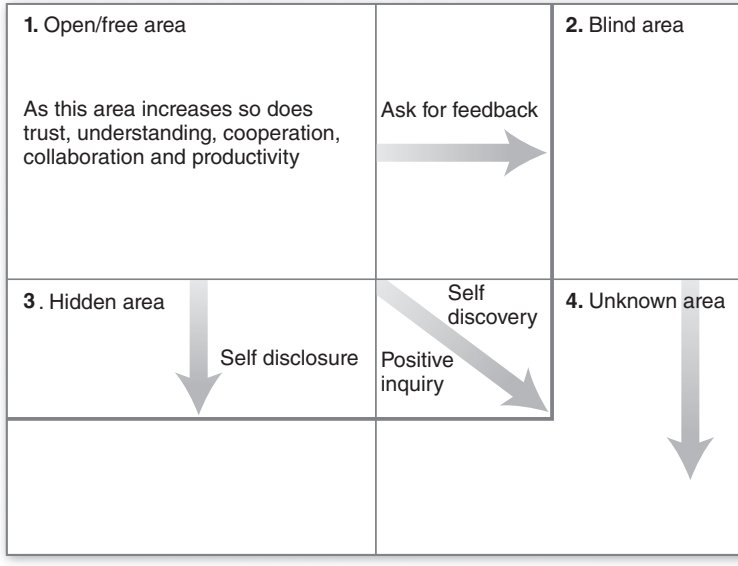

FIGURE 3-2 Feedback and self disclosure and the Johari window.

Data from Luft, J., Ingham, H. (1950). The Johari window, a graphic model of interpersonal awareness. *Proceedings of the Western Training Laboratory in group development*. Los Angeles, CA: UCLA.

With the realization that our perceptions of present situations are formed through the lens of our own life experiences, we begin to seek information from others in order to construct a more complete picture. The ability to separate our perceptions from actuality allows us to become emotionally independent, no longer bound by automatic negative responses to triggers or hot buttons, and better able to make strategic choices regarding our actions and reactions.

If the unknown area is not reduced, the group runs the risk of not being able to leverage all of an individual's talents. In addition, the individual runs the risk of not realizing his/her true potential—bound by old ways of knowing and reacting and reducing the chances of self-actualization and motivation to become engaged in the group's work. This type of awareness can be sparked through self-discovery, observations by others, and methods of inquiry that encourage mutual discovery. Leaders and members who use positive communication to facilitate self-discovery, solicit and provide constructive feedback, and foster the free flow of information create a psychologically safe environment that engenders creativity, productivity, and sustained high performance.

CASE STUDY: COMMUNICATION STYLE MATCH

Members of the interprofessional team on a geriatric unit (physician, nurse, physical therapist, occupational therapist, and social worker) are meeting to discuss patient safety on the unit. During the previous quarter, falls increased by 10%. Analysis of the incident reports indicates that an examination of the fall prevention program that is offered jointly by nursing, physical therapy, and occupational therapy is indicated. The team is meeting with the goal of designing a revised fall prevention program for the unit. The proposed program will need to be based in the most current evidence, ensure the safety of the patients, and be cost effective. All four styles of communication noted previously in this chapter—action oriented (physician and physical therapist), process oriented (occupational therapist), people oriented (social worker), and idea oriented (nurse)—are represented. The leader (in this case, it is the physical therapist) is an identified action-oriented communicator. In preparation for the first meeting, she reviews strategies for adjusting her communication style to the team members and prepares her opening remarks. Her remarks might vary depending on how she perceives the other members of the group. She lists pointers

CASE STUDY (*continued*)

for addressing the others based on their communication styles, along with alternate statements for each type.

COMMUNICATING WITH AN ACTION-ORIENTED PERSON:

- Focus on the results first.
- State your best recommendation.
- Emphasize the practicality of your idea.

At the first meeting, if the other members are action oriented, the physical therapist might say, "The purpose of this group is to address the increased number of falls on the unit this last quarter. We need to revise the fall prevention program that is currently offered. I recommend that we construct a program around the three components that have been identified in the literature. Developing a fall prevention program that includes exercise, fall prevention, and environmental components is the most effective focus."

COMMUNICATING WITH A PROCESS-ORIENTED PERSON:

- State the facts.
- Present your thoughts in a logical manner.
- Include options with pros and cons.
- Do not rush the person.

If the other members are process oriented, the physical therapist might say, "The purpose of this group is to address the increased number of falls on the unit this last quarter. We need to revise the fall prevention program that is currently offered. One option that we may choose to pursue is to do a literature review on the efficacy of fall prevention and develop a custom program for our unit. We may also explore the option of purchasing existing modules. What are your thoughts?"

COMMUNICATING WITH A PEOPLE-ORIENTED PERSON:

- Allow for small talk at the beginning of a session.
- Stress the relationship between the proposal and the people concerned.
- Show how the idea worked well in the past.
- Show respect for people.

(*continues*)

CASE STUDY (*continued*)

The physical therapist might say to such a group, "The purpose of this group is to address the increased number of falls on the unit this last quarter. Each of you has been chosen for this team because of your demonstrated commitment to patient safety. You are the experts in the day-to-day care of our patients. One area that we may need to consider is a revision of the fall prevention program that we currently offer. Institutions that are similar to ours have reported great success in reducing patient falls using a combination of exercise, addressing fear of falling, and modifying the environment."

COMMUNICATING WITH AN IDEA-ORIENTED PERSON:

- Allow enough time for discussion.
- Do not get impatient when they go off on tangents.
- Be broad and conceptual in your opening.

The physical therapist could address this type of group by saying, "As key staff members on this geriatric unit, you have demonstrated your commitment to patient safety. I have asked each of you to be a member of this team because we have yet another safety concern. The purpose of this group is to address the increased number of falls on the unit this last quarter. We need to revise the fall prevention program that is currently offered. Yes, the plan for tornado drills has been effective. Is there anything that we learned during the development and implementation of the tornado drill policy that we can bring to the creation of a fall prevention program?"

By acknowledging the presence of a variety of communication styles and adjusting her approach, this leader has demonstrated respect for team members and hopefully avoided potential problems in team communication at the beginning of this important project.

Communication Networks

In the 1950s, Leavitt (1951) graphically described common communication networks in small groups using circles and arrows to illustrate how information is processed and distributed. Simple tasks that require the processing of limited amounts of information are most efficiently carried out in centralized networks like the wheel, where one person serves as the hub for information exchange (**Figure 3-3A**). More complex

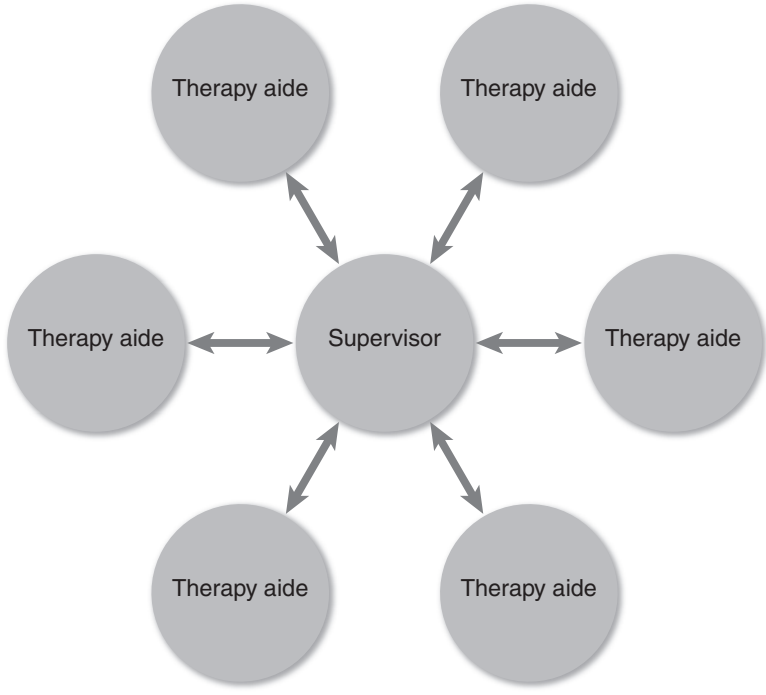

FIGURE 3-3A A centralized network.

tasks, which require the processing of large amounts of complex information, are most efficiently handled by decentralized networks of communication such as a circle, where there is a free-flowing information exchange among all participants (**Figure 3-3B**). In the current health care environment, a spider web might be a more appropriate metaphor for the complex communication networks through which vast amounts of complex information travels with the help of information and communication technologies (Mo, 2016).

Attention to the analysis of social networks and information exchange is crucial to understanding the problem solving and intraorganizational learning capacity of complex health systems. Knowledge-intensive health care organizations depend upon high-functioning teams with communication networks that emphasize a free flow of information that is unconstrained by hierarchy or discipline (Stokols, Hall, Tylor, & Moser, 2008; Gray, 2008; Agneessens & Wittek, 2012).

Systematic observation of communication patterns provides insight into how the flow of information is related to power and influence within teams. Lower-status individuals are less likely to express their thoughts

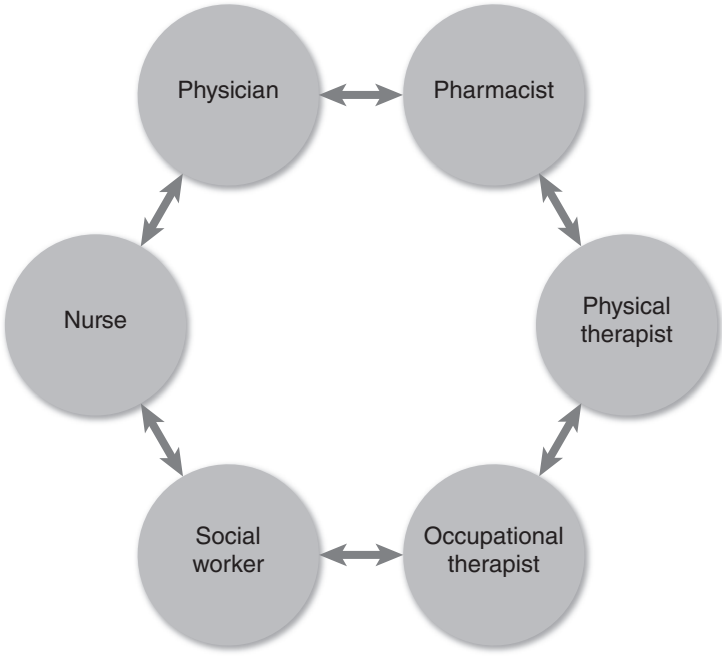

FIGURE 3-3B A decentralized network.

and feelings in groups with people of higher status. Higher-status individuals tend to do more of the talking. According to the Institute of Medicine (2003), hierarchical communication patterns are partially responsible for medical errors. Additional challenges to communication

COMMUNICATION NETWORKS

Simple tasks, like stocking supply closets in the therapy gyms, requires the processing of limited amounts of information and can be most efficiently carried out in a centralized network like the wheel. A supervisor (hub of the wheel) might direct therapy aides via e-mail or face-to-face communication. More complex tasks, like developing a comprehensive patient discharge plan, requires the processing of large amounts of complex information and might be most efficiently handled by decentralized networks of communication between the physician, nurse, therapists, social worker, and other professionals, using face-to-face and virtual conferencing with the electronic health record.

may also exist along gender and generational lines (Spector, 2010). Communication patterns in teams that employ collaborative processes like directness, mutual understanding, and full participation of members tends to create a climate of psychological safety across the hierarchies and results in more inclusive communication and more effective and efficient exchange of information (Meads & Ashcroft, 2005; Nembhard & Edmondson, 2006).

Healthcare organizations are composed of a diverse network of health professionals, patients, and caregivers who must leverage each other's expertise by coordinating the exchange and flow of highly complex data. Health information technology (HIT) professionals can help to design information exchange strategies that distribute leadership and facilitate accountability and engagement of every member of the team (Gray, 2008; Hammick, Freeth, Copperman, & Goodsman, 2009; Christopherson, Troseth, & Clingerman, 2015). HIT can support collaborative practice when its design is informed by the culture, values, and goals of the health system. Health professionals' contributions to the electronic health record usually address patient's history, plan of care, assessments, education, and transitions or "handoffs" to other levels of care. Each of these areas provides opportunities for interprofessional communication, role delineation and overlap, collaboration, and shared decision-making. If a health system's goal is to provide evidence-based, interprofessional, patient-centered care, HIT tools must be designed to support those goals. The electronic health record, enhanced with contextually relevant hardware and software, can become a nexus for various viewpoints that informs collaborative, patient-centered decision-making (Christopherson, Troseth, & Clingerman, 2015). High-quality feedback among interdependent team members yields high levels of cohesion, satisfaction, and performance in teams (Garman, 2010; Gittell, 2009; Goleman, Boyatzis, & McKee, 2002).

Online communities and social media platforms offer opportunities for healthcare providers and health care consumers to collaborate and share practical knowledge in spite of geographical distance, scheduling conflicts, and status differentials. While it is true that this type of increased interaction can facilitate empathy, trust, and cohesion, technology alone does not create collaborative cultures. A culture of collaboration is an important prerequisite for sustainable integration of technology and health care (Norman & Yip, 2013; Christopherson, Troseth, & Clingerman, 2015; Kotlarsky, van den Hooff, & Houtman, 2015). Institutions that invest in the development of relationships through formal structures that support frequent and consistent time allocation for

team meetings—face-to-face and electronic—will find that gains in patient outcomes will mirror gains in social capital (Drinka & Clark, 2000; Ghaye, 2005; Gittell, 2009; Institute of Medicine, 2003; Lawrence, 2002; Ratcheva, 2009; Norman & Yip, 2013).

Administrators and clinicians find it difficult to justify taking time away from direct patient care in order to attend meetings because the fast-paced healthcare environment places time at a premium. However, recent healthcare reforms have linked reimbursement to patient outcomes such as length of stay, readmission rates, and patient satisfaction rather than the number of procedures and services provided. While one could argue that the time spent in meetings is not reimbursable, it would be hard to deny that the improvements in team communication and performance positively affect team sustainability and patient outcomes.

Collaborative, participative environments engender increased knowledge and mutual respect among health team members. Increased awareness of the expertise available to the team will facilitate the team's ability to distribute leadership based on the nature of the challenge and disciplinary boundaries can become points of connection and innovation rather than points of contention (Drinka & Clark, 2000; Gray, 2008; Meads & Ashcroft, 2005; Wheatley, 2006). Leaders who are willing to trust in the diverse wisdom and singular intent of the collective actively encourage and seek participation from all members of the team. Consequently, communication disparities are mitigated and psychologically safe team environments are created. All members are encouraged to contribute, exercise leadership, and be personally engaged and accountable for the team outcomes. (Nembhard & Edmondson, 2006; Wheatley, 2006).

CASE STORY: *Technology and Communication in an Interprofessional Setting*

At Austill's Rehabilitation Services, Inc., all managers can access our secure network that allows 24:7 access to our e-mail, voicemail, and custom-designed database, which has current and prospective client information. Our 400 school-based occupational, physical, and speech therapists all have access to our secure accountability, billing, and data collection systems via personal laptops or tablets, which enhances workplace portability and efficiency. WEB-based IEPs (Individualized Educational Programs) have greatly expanded interprofessional team communication. Each team

CASE STORY (*continued*)

member's student assessment, summary, recommendations, and daily progress is communicated to the team, which facilitates consistent collaboration even though our therapists are in different locations.

Our managers can e-mail or text therapists in the field or administrative support staff during meetings and receive immediate feedback. We also use Skype, FaceTime, and videoconferencing to interview potential employees, as an adjunct to on-site supervision of staff, to participate in university-based educational activities, and to have access to specialists who provide live, timely support to our therapists. Technology has helped us to facilitate interprofessional communication and skill development within our organization and with partners outside of our organization, and has positively impacted the outcomes for our clients.

—Rebecca Austill-Clausen, MS, OTR/L, FAOTA, Founder, Austill's Rehabilitation Services, Inc., Exton, PA

REFLECTION: *Identifying Opportunities for Collaboration*

Health professionals' contributions to the electronic health records usually address the following areas. In your setting, which areas provide opportunities for communication, collaboration, role delineation, role overlap, and shared decision-making?

History

Plan of care

Assessments

Education

Transitions (hand offs)

References

Agneessens, F., & Wittek, R. (2012). Where do intra-organizational advice relations come from? The role of informal status and social capital in social exchange. *Social Networks, 34*(3), 333–345.

Belbin, R. (2010). *Team roles at work* (2nd ed.). Burlington, MA: Butterworth Heinemann/Elsevier.

Benne, K., & Sheats, P. (1948). Functional roles of group members. *Journal of Social Issues, 4*(2), 41–49.

Christopherson, T., Troseth, M., & Clingerman, E. (2015). Informatics-enabled interprofessional education and collaborative practice: A framework-driven approach. *Journal of Interprofessional Education & Practice, 1*, 10–15.

Doucet, H., Larouche, J., & Melchin, K. (2001). *Ethical deliberation in multiprofessional health care teams*. Ottawa, Canada: University of Ottawa Press.

Drinka, T., & Clark, P. (2000). *Health care teamwork: Interdisciplinary practice and teaching*. Westport, CT: Auburn House.

Freshman, B., Rubino, L., & Chassiakos, Y. (2010). *Collaboration across the disciplines in health care*. Sudbury, MA: Jones and Bartlett Publishers.

Garman, A. (2010). Leadership development in the interdisciplinary context. In B. Freshman, L. Rubino, & Y. Chassiakos (Eds.), *Collaboration across the disciplines in health care* (pp. 43–64). Sudbury, MA: Jones and Bartlett Publishers.

Ghaye, T. (2005). *Developing the reflective healthcare team*. Oxford, UK: Blackwell Publishing, Ltd.

Gittell, J. (2009). *High performance healthcare: Using the power of relationships to achieve quality, efficiency and resilience*. New York, NY: McGraw-Hill.

Goleman, D., Boyatzis, R., & McKee, A. (2002). *Primal leadership: Learning to lead with emotional intelligence*. Boston, MA: Harvard Business School Press.

Gray, B. (2008). Enhancing transdisciplinary research through collaborative leadership. *American Journal of Preventive Medicine, 35*(2S), s124–s132.

Hammick, M., Freeth, D. S., Copperman, J., & Goodsman, D. (2009). *Being interprofessional*. Malden, MA: Polity Press.

Institute of Medicine, Committee on the Health Professions Education Summit; Greiner, A. C., & Knebel, E. (Eds.). (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academies Press.

Klein, J. (2010). *Creating interdisciplinary campus cultures: A model for strength and sustainability*. San Francisco, CA: Jossey-Bass.

Kotlarsky, J., van den Hooff, B., & Houtman, L. (2015). Are we on the same page? Knowledge boundaries and transactive memory system development in cross functional teams. *Communication Research, 42*(3), 319–344.

Lawrence, D. (2002). *From chaos to care: The promise of team based medicine*. Cambridge, MA: Perseus Publishing.

Leavitt, H. (1951). Some effects of certain communication patterns on group performance. *Journal of Abnormal and Social Psychology, 46*, 38–50.

Lewin, K. (1943). Defining the "field at a given time." *Psychological Review, 50*, 292–310.

Locke, E. A., Latham, G. P., & Erez, M. (1988). The determinants of goal commitment. *Academy of Management Review, 1*, 23–39.

Luft, J., & Ingham, H. (1950). The Johari window, a graphic model of interpersonal awareness. *Proceedings of the Western Training Laboratory in group development*. Los Angeles, CA: UCLA.

Meads, G., & Ashcroft, J. (2005). *The case for interprofessional collaboration in health and social care*. Oxford, UK: Blackwell Publishing, Ltd.

Mo, G. (2016). Examining cross-disciplinary communication's impact on multidisciplinary collaborations: implications for innovations. *Information, Communication & Society*, DOI: 10.1080/1369118X.2016.1139611

Nash, J. (2008). Transdisciplinary training: Key components and prerequisites for success. *American Journal of Preventative Medicine, 35*(2S), s133–s140.

Nembhard, I., & Edmondson, A. (2006). Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. *Journal of Organizational Behavior, 27*, 941–966.

Norman, C., & Yip, A. (2013). Chapter 34: Designing for health promotion, social innovation, and complexity: the CoNEKTR Model for wicked problems. In Sturmberg, J. & Martin, C., (eds.), *Handbook of systems and complexity in health* (pp. 581–593). New York, NY: Springer Science+Business Media.

O'Daniel, M., & Rosenstein, A. H. (2008, April). Chapter 33: Professional communication and team collaboration. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses* (pp. 271–284). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK2637/

Ratcheva, V. (2009). Integrating diverse knowledge through boundary spanning processes: The case for multidisciplinary project teams. *International Journal of Project Management, 27*, 206–215.

Seltman, K., & Berry, L. (2013). Mayo Clinic: Making complex healthcare simpler. In Sturmberg, J., & Martin, C. (Eds), *Handbook of systems and complexity in health* (pp. 685–696). New York, NY: Springer Science+Business Media.

Sherif, M. (1936). *The psychology of social norms*. New York, NY: Harper & Row.

Silver, W., & Bufanio, K. (1996). The impact of group efficacy and group goals on group task performance. *Small Group Research, 27*, 347–359.

Spector, N. (2010). Interprofessional collaboration: A nursing perspective. In F. Freshman, L. Rubino, & Y. Chassiakos (Eds.), *Collaboration across the disciplines in healthcare.* (p. 107). Sudbury, MA: Jones and Bartlett Publishers.

Stokols, D., Hall, K., Tylor, B., & Moser, R. (2008). The science of team science. *American Journal of Preventative Medicine, 35*(2S), s77–s89.

Torrens, P. (2010). The health care team members: Who are they and what do they do? In B. Freshman, L. Rubino, & Y. Chassiakos (Eds.), *Collaboration across the disciplines in health care* (pp. 1–19). Sudbury, MA: Jones and Bartlett Publishers.

Wheatley, M. (2006). *Leadership and the new science: Discovering order in a chaotic world* (3rd ed.). San Francisco, CA: Berrett-Koehler Publishers, Inc.

Wheelan, S. (2005). *Group process: A developmental perspective* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Wooley, A., Malone, T., & Chabris, C. (2015, January 16). Why some teams are smarter than others. *The New York Times*. Retrieved from http://www.nytimes.com

Youker, R. (1996). Communication style instrument: A team building tool. In *PMI seminars & symposium proceedings* (pp. 796–799). Upper Darby, PA: Project Management Institute.