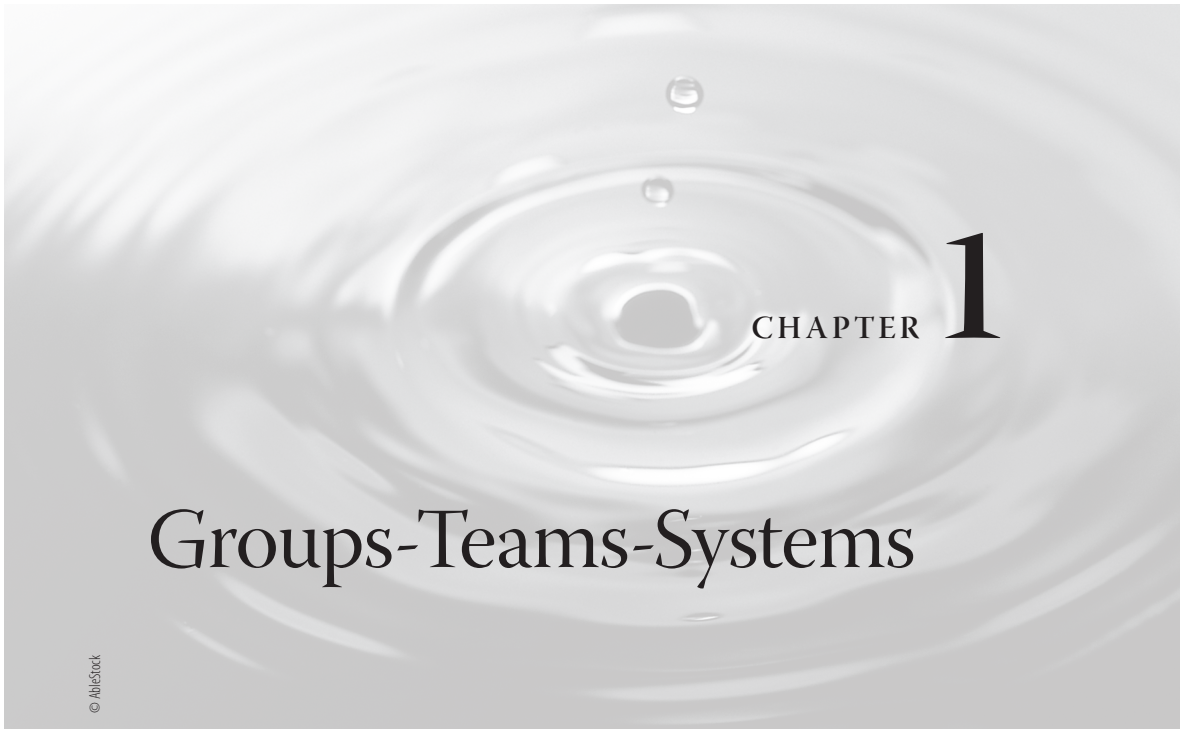
Teamwork and Group Development

"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 leader—they cannot help but eventually have a positive influence on the total function and structure of any system."

Shaffer & Gallinsky, 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. Understand 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, in friendship groups, in sports, neighborhoods, in work groups, and recently in electronic social networks like Facebook. 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 these challenges, we

have the opportunity for collective wisdom to emerge. 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 that we often refer to as 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*

Here, everything is a committee decision. You can have input from multiple perspectives such as nursing, social work, occupational therapy, physical therapy, 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, LIFE (Living Independently for Elders) Practice, School of Nursing, University of Pennsylvania.

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; Wheelan, 2004).

What Is the Difference Between a Team and a Group?

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 from the Italian *gruppo*, which was borrowed originally from prehistoric Germanic *kruppaz*, which is translated into a "round mass, lump" (http://www.wordorigins.org/word-origins.com). This is hardly what we think of when we talk about work teams today. The term *group* is defined by Merriam Webster (2011, group entry) as "A number of individuals assembled together or having some unifying relationship." The origin of *team* is defined as a group that engages in more focused intentional action. The word derives from the Middle English term *teme* and the Old English *tēon* which is to draw or pull (Merriam Webster, 2011). Katzenbach and Smith (1993) describe

REFLECTION: *Identification of Groups*

Rank in order the 10 descriptions below with No. 1 being the most group-like and No. 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 Jane Smith, their daughter)

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" (pp. 112).

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

Students in a classroom	Advisory Committee	ER Team
Group = A collection of people who have something in common.		Team= A group of people who must work together to reach common goals or outcomes.

FIGURE 1-1 Group-team continuum.

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 eighteenth-century German philosopher, Hegel, introduced systems theory by suggesting that the whole is more than the sum of its parts, that 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, 1968). From a systems theory point of view, 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 open systems theory further when they proposed a method to analyze open (living) social systems using the systems theory. 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 from the external environment or input is provided by hospital staff, care recipients, suppliers, and funding sources. 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).

Suchman, Sluyter, and Williamson (2011) provide an apt metaphor for healthcare organizations that is in keeping with the principles of open systems:

> 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).

The organizational conversations reflect the organization's values, mission, culture, knowledge base, and interactive patterns or group dynamics. Organizations that attempt to impose a mechanistic, linear orientation upon an inherently open system such as a group, organization or community discount the value and challenges of randomness. These tightly coupled systems find themselves too rigid to respond to internal or external signals for the need 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 sets the boundaries for their collective creativity, productivity, and outcomes (Vickers, 1983; Weick, 1976).

Systems, subsystems, and the environment, while defined by boundaries, are interactive and interdependent. The dynamic relationship between structure and function of all aspects of the system and its environment render the boundaries permeable. 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

CONVERSATION DYNAMIC

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.

FIGURE 1-2

(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 (Gittel, 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 equal recognition of each team member's contribution broaden the perspective of the team. In addition, increased 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 social system, it is helpful to understand that there are levels of the system, which include individual, interpersonal, group, organizational, and community.

Individual: One person.
Interpersonal: Dyads.
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 is often targeted at the level of system where the impact will be the greatest. Successful change agents, whether they are leaders or members of groups, learn to differentiate between system levels and to 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). 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 group-level intervention in relation to the other levels of system.

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.

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TABLE 1-1 Intervention at Each Level of System *(Continued)*

Level	Focus	Goal	Methods
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.

LEVEL OF SYSTEMS CASE STUDY: *Stephanie's Dilemma*

The vice president of hospital facility services, Stephanie Scardola, was struggling with a problem.

A new human resources (HR) director for facilities services, Colin Doyle, was hired six months previously. In the past, this position was filled by former administrative assistants in the hospital system and served as a professional development step towards a more responsible management positions. Most of the people who held this position left within two years to go on to another position in the hospital or in another hospital system. The committee felt that it was time to hire someone with more HR experience and with an outsider's point of view even though the compensation and job level was still the same.

Colin came from a small, nonprofit company and has eight years of HR experience. He never worked in a hospital nor did he have union experience; however, the committee hired him because he was the most experienced candidate, had a master's degree in HR, and was professional and

knowledgeable. This HR position reports to both the vice president of facility services and an HR director from the hospital's central HR department. The duties include partnering with managers in the facilities department, helping them deal with union and nonunion discipline issues, being responsible for getting people paid properly, and making sure all of the proper paperwork is in order and sent to central HR.

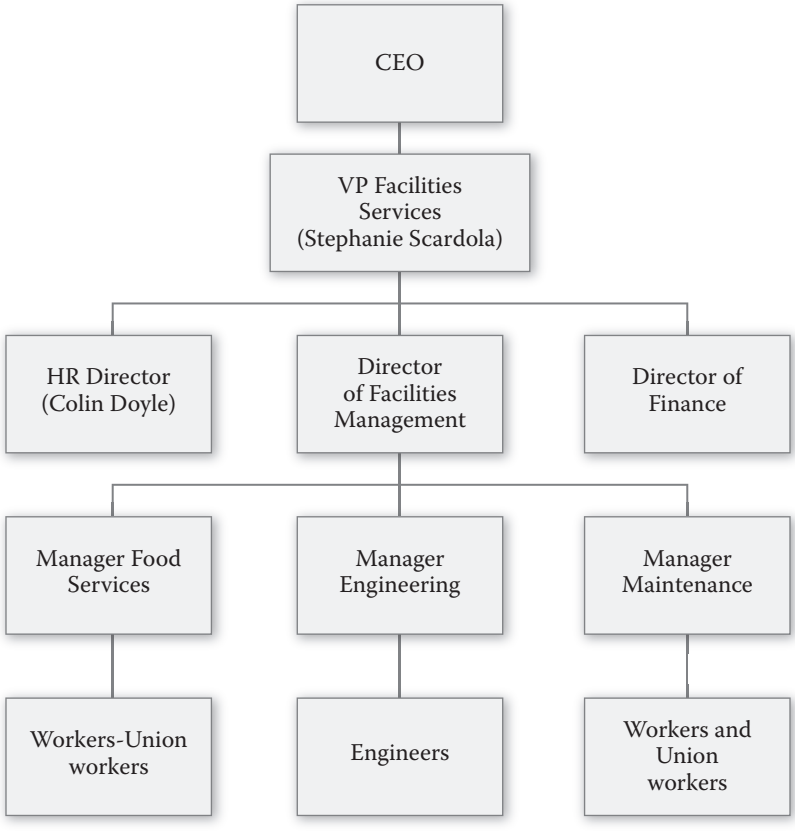

FIGURE 1-3

When Colin was first hired, he performed well. He conducted several employee orientation training sessions and was able to put two new policies in place to assist the facilities services managers in handling some situations on their own. Unfortunately, problems began a few months later. Colin was not keeping up with emails, he made some vital mistakes with

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some employees under union contracts, and he overpaid two employees, along with other issues.

Stephanie met with Colin about all of these issues and each time there were valid reasons why errors occurred. He informed Stephanie that employees often took issues directly to central HR, bypassing him, and therefore he did not know about those problems until it was too late to solve them. Managers were either not coming to him with issues or also were coming after the damage was already done. He did remind Stephanie that he was on a learning curve and some of the mistakes were due to his own lack of experience. He also needed to become more familiar with the new union contract. On a personal level, he said there was too much on his plate; he was a single dad and could not work late every night.

About three months earlier, the Director of Facilities Management left his position and Stephanie had been filling this role as well as taking care of her duties as a member of the senior team of the hospital. Due to this position, she was getting direct feedback from managers that Colin did not answer his emails. Although he was responsive when addressed in person, he was sometimes a bit glib and rule based and answered questions too quickly. The managers were also concerned that when Colin spoke to the union employees he was too sympathetic toward them. He seemed to buddy up to them and seemed to lose his professional demeanor.

The Chief Executive Officer (CEO) found out that the Director of Facilities Management position was open and would remain that way for six months. The managers, at this point, were all reporting to Stephanie. Stephanie was extremely busy running the operation and working with funding and other issues outside of the organization, which were more critical parts of her responsibilities.

QUESTIONS:

1. Look at the row labeled "Individual" in Table 1.1. Assume Colin is the individual. Describe which intervention technique you would apply and how this would positively impact Colin's behavior.
2. Look at the row labeled "group" in Table 1.1. Assume the group consists of Stephanie and the three Directors. Describe which intervention technique you would apply and how this could help this group better reach its goals.

3. You are the CEO. Look at the row labeled "organization" in Table 1.1. Describe which intervention technique you would apply and how this could make a positive impact on Stephanie's Dilemma.
4. After looking at this from all three perspectives, what do you think would be the preferred way to handle the issue?

References

Alderfer, C. P. (1977). Organization development. *Annual Review of Psychology, 28*, 197–223.

Banathy, B. H., & Jenlink, P. M. (2004). Systems inquiry and its application in education. In D. H. Jonassen (Ed.) *Handbook of Research on Educational Communications and Technology* (p. 37–57). Mahwah, NJ.: Lawrence Erlbaum Associates

Briskin, A., Erickson, S., Ott, J., & Callanan, T. (2009). *The power of collective wisdom and the trap of collective folly*. San Francisco, CA: Berrett-Koehler.

Cartright, D., & Zander, A. (1968). *Group dynamics: Research and theory*, New York, NY: Harper & Row Publishers.

Forsyth, D. R. (2006). *Group dynamics* (4th ed. [international student ed.]). Belmont CA: Thomson Wadsworth Publishing.

Gillette & McCollom, M. (1990). *Groups in context: A new perspective on group dynamics*: Lanham, MD: University Press.

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

Grant R., & Finocchio, L., California Primary Care Consortium Subcommittee on Interdisciplinary Collaboration. (1995). *Interdisciplinary collaborative teams in primary care: A model curriculum and resource guide*. San Francisco, CA: Pew Health Professions Commission.

Group. (2011). In *Merriam-Webster.com*. Retrieved from http://www.merriam-webster.com/dictionary/group

Katz, D. & Kahn,R. (1978). *The social psychology of organizations*. Hoboken, NJ: Wiley.

Katzenbach, J.R. & Smith, D.K. (1993). *The Wisdom of Teams: Creating the High-performance Organization*. Boston: Harvard Business School.

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

Lewin, K. (1948). *Resolving social conflicts: Selected papers on group dynamics*. Gertrude W. Lewin (Ed.). New York, NY: Harper & Row.

Meyer, R. M., & O'Brien-Pallas, L. L. (2010). Nursing services delivery theory: An open system approach. *Journal of Advanced Nursing, 66*(12), 2828–2838.

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.

Reed, D., Fletcher, K., & Arora, V. (2010). Systemic review: Association of shift length, protected sleep time and night float with patient care, residents' health and education. *Annals of Internal Medicine, 153*, 829–842.

Singh, S. (2000). Running an effective community mental health team. *Advances in Psychiatric Treatment, 6*, 414–422.

Smith, M. (2008). *Experience in groups and other papers*. New York, NY: Tavistock Publications Limited.

Studer, Q. (2003). *Hardwiring excellence: Purpose, worthwhile work, making a difference*. Gulf Breeze, FL: Fire Starter Publishing.

Suchman, A., Sluyter, D., & Williamson, P. (2011). *Leading change in healthcare: Transforming organizations using complexity, positive psychology and relationship-centered care*. London, England: Radcliffe Publishing.

Team. (2011). In *Merriam-Webster.com*. Retrieved from http://www.merriam-webster.com/dictionary/team

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

Vickers, G. (1983). *Human systems are different*. London, England: Harper and Row.

Weick, K. (1976). Educational organizations as loosely coupled systems, *Administrative Science Quarterly, 21*, 1, 1–19.

Wells, L. (1995). The group as a whole: A systemic socio-analytic perspective on interpersonal and group relations. In G. Gillette, & M. McCollum (Eds.), *Groups in context* (pp. 50–85) Lanham, MD: University Press of America.

Wheatley, M. (2005). *Finding our way*. San Francisco, CA: Berret-Koehler Publishers, Inc.

Woltmann, E., Whitley, R., McHugo G., Brunette, M., Torrey, W. Coots, L., Drake, R. (2008, July). The role of staff turnover in the implementation of evidence-based practices in mental health care. *Psychiatric Services, 59*, 732–737.