

## FACTORS INFLUENCING THE EFFECTIVENESS OF HEALTH TEAMS

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Group practice in health care delivery takes many forms. The term “group practice” usually refers to a group of professionals who combine their resources in delivering treatment care to a patient population. Some of these groups are actively involved in preventive medicine efforts. Because of heavy work loads, more and more activities are being delegated to nurses, physicians assistants and, in some cases, community-based family health workers. One common condition in all of these settings is that a group is doing the “practicing.”

The effectiveness of any group in any setting is related to *both* its capabilities to do the work and its ability to manage itself as an interdependent group of people. The central focus of this paper will be upon the internal dynamics involved when a collection of individuals attempts to function as a group. The objective is to provide a framework that will facilitate consideration of several important issues involved in the more effective utilization of groups in delivering health care.

We will begin by drawing upon the general body of knowledge about groups and their dynamics developed within the behavioral sciences. Several key variables known to be of prime importance in any group situation will be discussed. Next, we will discuss the particular relevance of these variables to group medical practice.

Third, we will draw upon our own experience in helping several health teams improve their effectiveness. The setting for this effort was a community health center, located in a low income urban area, concerned with providing comprehensive, family centered health care using health teams<sup>1</sup> as the main "delivery system."<sup>2</sup>

We will then discuss some issues that apply to a variety of health care delivery settings, where groups are collaborating on the delivery. Finally, we will indicate some issues for the education and training of health workers who will be functioning in groups.

## THE DYNAMICS OF GROUPS

This section will present and briefly define seven selected characteristics or variables known to be of importance in any group situation.<sup>3</sup> Each characteristic can be viewed as a scale or yardstick against which one can ask the question: is this particular group (made up of certain kinds of people, trying to do a given task in this situation) located where it needs to be on each of these scales to function most effectively?

### *Goals or Mission*

A team or group has a purpose. There exists a reason (or reasons) for the formation of the group in the first place. Any group, therefore, will be confronted with issues such as:

1. how clearly defined are the goals? Who sets the goals?
2. how much agreement is there among members concerning the goals? How much commitment?
3. how clearly measurable is goal achievement?
4. how do group goals relate to broader organizational goals? To personal goals?

Since a group's very existence is to achieve some goal or mission, these issues are of central importance.

### *Role Expectations: Internal*

In working to achieve their goals, group members will play a variety of roles. Among the members of a group a set of multiple expectations exists concerning role behavior. Each person, in effect, has a set of expectations of how each of the other members<sup>4</sup> should behave as the group works to achieve its goals. In any group, therefore, questions exist about: (1) the extent to which such expectations are clearly defined and communicated (role ambiguity); (2) the extent to which such expectations are compatible or in conflict (role conflict); (3) the extent to which any individual is capable of meeting these multiple expectations (role overload).

These role expectations are messages “sent” between the members of a group. Generally, the more uncertain and complex the task, the more salient are issues of role expectations.

### *Role Expectations: External*

Any individual is a member of several groups. Each group of which he is a member has expectations that can influence his behavior. The director of pediatrics in a hospital, for example, is “simultaneously” the manager of his group, a subordinate, a member in a group of peers (directors of the functional areas), a member of a hospital staff, a father, husband and so forth.

Each of these “reference” groups, as they are called, holds expectations of a person’s behavior. Together they can be ambiguous, in conflict or create overload. These multiple reference group loyalties can create significant problems for an individual in terms of his behavior as a member of a particular group. Although the source of the conflicts involved in the question of reference group loyalties is external to a particular group, it can have significant internal effects.

### *Decision-making*

A group is a problem-solving, decision-making mechanism. This is not to imply that an entire group must always make all decisions as a group. The issue is one of relevance and ap-

appropriateness; who has the relevant information and who will have to implement the decision. A group can choose from a range of decision-making mechanisms including decision by default (lack of group response), unilateral decision (authority rule), majority vote, consensus or unanimity. Each form is appropriate under certain conditions. Each will have different consequences both in terms of the amount of information available for use in making the decision, and the subsequent commitment of members to implement the decision.

Similarly, when a group faces a conflict it can choose to ignore it, smooth over it, allow one person to force a decision, create a compromise or confront all the realities of the conflict (facts and feelings) and attempt to develop an innovative solution. The choices it makes in both of these areas will significantly influence group functioning.

### *Communication Patterns*

If, indeed, a group is a problem-solving decision-making mechanism, then the effective flow of information is central to its functioning. Anything that acts to inhibit the flow of information will detract from the group effectiveness. A range of factors affects information flow. At a very simple level are the architectural and geographic issues. Meeting space can be designed to facilitate or hinder the flow of communication. Geographically separated facilities may be a barrier to rapid information exchange. Numerous subtler factors must also be considered. Participation—frequency, order and content—may follow formal lines of authority or status. High-status members may speak first, most and most convincingly on all issues. The best sources of information needed to solve a problem will, however, vary with the problem. Patterns of communication based exclusively on formal lines of status will not meet many of the group's information needs. People's feelings of freedom to participate, to challenge, to express opinions also significantly affect information flow.

## *Leadership*

Very much related to the processes of decision-making and communication is the area of leadership. To function effectively, a group needs many acts of leadership; not necessarily one “leader” but many leaders. People often misinterpret such a statement as saying “good groups are leaderless.” This is not the intent. Depending on the situation and the problem to be solved, different people can and should assume leadership. The formal leader of a group may be in the best position to reflect the “organization’s” position on a particular problem. Someone else may be a resource in helping the formal leader and another member clarify a point of disagreement. All are examples of necessary acts of leadership. It is highly unlikely that in any group one person will be capable of meeting all of a group’s leadership needs.

## *Norms*

Norms are unwritten (often untested explicitly) rules governing the behavior of people in groups. They define what behavior is “good or bad,” “acceptable or unacceptable” if one is to be a functioning member of this group. As such, they become very powerful determinants of group behavior and take on the quality of laws—“it’s the way we do things around here!” Their existence is most clear when they are violated; quiet uneasiness, shifting in one’s seat, joking reminders, are observable. Repeated violation of norms often leads to expulsion, psychological or physical.

Norms take on particular potency because they influence all of the other areas previously discussed. Groups develop norms governing leadership, influence, communication patterns, decision-making, conflict resolution and the like. Inherently, norms are not good or bad. The issue is one of appropriateness—does a particular norm help or hinder a group’s ability to work?

These seven factors, then, are characteristics of any group

situation. Where a particular group needs to be on each of these “yardsticks” is a function of the situation. We turn now to look at these factors within the setting of health teams.

#### THE DYNAMICS OF A HEALTH TEAM

Our intention in this section is to look at these factors affecting group functioning and to relate them to a group<sup>5</sup> setting (community based, total health care). The center in which we have worked<sup>6</sup> is the particular situation from which we will draw examples and observations. However, the issues raised are broadly relevant.

##### *Goals or Mission*

A health team striving to provide “comprehensive family centered health care” faces uncertainties substantially different from those one might find in a hospital setting. The goals<sup>7</sup> in a hospital are relatively clear: remove the gall stone, deliver the baby. Success is measurable and clear. Seldom are social factors of prime importance. The thrust is curative and the emphasis is medical.

The community oriented health teams we have studied experience considerable uncertainty over their mission. “Comprehensive” means the team can not ignore social problems and emphasize the “relative security and certainty” of medical problems. Considerable anxiety is generated because the team does not really know when and if it is succeeding. The questions of priorities and time allocations become complicated; how does one decide between competing activities in the absence of clearly defined goals? A team member wonders whether to spend one-half a day trying to arrange for a school transfer for a child or see the other patients scheduled for visits.

No one member of the team has been trained to be knowledgeable in all the areas required. Yet, the complexity of the task demands that doctors become involved in social problems; nurses become the supervisors of paraprofessional family health

workers who are an integral part of the team; and these community based family health workers become knowledgeable in diagnosing and treating psychiatric problems. This is not to say everyone should become an expert at solving all problems. The requirements are for considerable information collection, sharing and group planning so that the team has all the available information to deploy its total resources to the task.

The anxieties and frustrations created by the complexity of the task are inevitable—an inherent part of providing “comprehensive” care.<sup>8</sup> A major team dilemma is one of managing short-versus long-run considerations—to give itself short-run security and direction while not losing sight of its long-run, vague and global goal.

#### *Role Expectations: Internal and External*

The nature of the task—comprehensive family centered health care—demands a highly diverse set of skills, knowledge and backgrounds. In creating a team, many “cultures” are of necessity being mixed and asked to work together.

As a result of educational background and training, the doctors are accustomed to being primary (if not sole) authority and most expert in medical issues. The specialist role for which they have been so well trained and that is so appropriate in a hospital setting comes under pressure. As a team member, in addition to his specialist skills, the doctor is asked to become more of a generalist. He needs to teach other health workers some of his medical knowledge. He also needs to learn from them more about the social problems facing the community and the character, mores and values of the particular patient population.

Doctors tend to maintain strong psychologic ties with their professional speciality groups. The stronger these ties for a physician the more difficult it will be for him to develop needed team loyalty. His sense of professionalism stems from these external reference groups. The careful hospital-type workup he has been so well trained to do may not be feasible or appropriate

in the face of the hectic schedule generated by large numbers of patients. The conflict may become one around “professional standards.” Comprehensive group practice may require a redefinition of these standards and perhaps even the redefinition of a professional.

Both the nurses and family health workers tend to bring a history of submissiveness. The nurses have been trained to be submissive to doctors. In this setting nurses find themselves as coordinators of the work of a team including doctors—a complete role reversal.

Family health workers in this case are local community residents, who, after six months of clinical training, suddenly find themselves defined as “colleagues” with middle-class physicians. They bring a deep concern for social problems coupled with the best understanding of what will or will not work with patients (their friends and relatives). The team needs their knowledge of the cultural norms of the community and their commitment to social issues. Their background and passive posture is often a barrier to the realization of these expectations.

Whereas the nurses and doctors have a professional reference group, the family health workers as yet have none. The resulting feelings of “homelessness” are heightened by their liaison role at the interface between the team and the community.\* Their membership and acceptance in the community is crucial to the team’s ability to be of service. They alone can serve to bridge the cultural gaps that exist.<sup>9</sup>

This set of conditions differs markedly from the hospital setting where strong reference group loyalties and clearly defined role expectations are common. Behaviors learned during one’s individual preparation are appropriately applicable in the vast majority of situations. Although professionals and para-professionals work in the same organization, seldom, if ever, are they asked to work in highly interdependent on-going stable groups.

\* Such people have been called marginal men. A foreman in a factory is another example—caught between the management culture and the worker culture.



A part of being a member of a highly interdependent team is the need to develop new loyalties and learn some new skills not anticipated or covered during individual training. In fact, it is unlikely that, in the face of the mission of providing "comprehensive family-centered health care," clearly defined, complete job descriptions will ever be feasible.<sup>10</sup> This reality puts great stress on a team's ability to learn and adapt by itself. In response to a particular problem, the question cannot be "Whose job is it?" but may instead have to be "Who on the team is capable?" or "Who needs to learn how to handle this situation?"

### *Decision-Making*

The inherent uncertainties in its mission and the diverse mix of skills represented on a health team suggest that decisions can seldom be appropriately made in a routine, programmable or unilateral manner. This is in sharp contrast to the majority of cases in the hospital setting in which is found the relative clarity and certainty of the goals and clearly defined roles and lines of authority.

One difficulty in any on-going team is the need to differentiate a variety of decision-making situations. In an attempt to be "democratic and participative" a team might try to make all decisions by consensus as a team. This represents a failure to distinguish, for example, (a) who has the information necessary to make a decision, (b) who needs to be consulted before certain decisions get made and (c) who needs to be informed of a decision after it has been made. Under certain circumstances the team may need to strive for unanimity or consensus; in other cases majority vote may be appropriate.

Perhaps the greatest barrier to effective decision-making in highly interdependent health teams stems again from the "cultural" backgrounds of team members. Doctors are used to making decisions by themselves or in collaboration with peers of equal status—other doctors or highly educated professionals. At the other extreme, the community residents who work on the team are used to being passive dependent recipients of

others' decisions. Yet many times, on a health team, the doctor and the community workers are and must behave as peers, neither one possessing all the information needed to solve a particular problem or make a particular decision. Furthermore, many times the doctor is the one who needs information held by another health worker. When a conflict develops, the required discussion that will lead to consensus is difficult to achieve; forcing, compromise or decision by default may result. Commitment to decisions is low with the result being that many decisions have to be remade several times—"I thought we decided that last week!" or "Didn't we decide that you would do such and such?"

The team approach to delivery of health care puts great stress on the need for numerous and various inputs to many decisions. When the decision-making process is inappropriate less information is shared, commitment is lowered and anxiety and frustration are increased.

### *Communication Patterns and Leadership*

Issues of communication patterns and leadership can be handled together for, as was true in the case of decision-making as well, the central theme is one of "influence." The leadership or influence structure—to which we have all become so accustomed via family, educational and organizational experiences and that is appropriate for, say, a hospital operating room—will be incapable of responding to the diversity of issues with which a health team must deal. In this setting each member is a resource. He must have open channels to all the other members. Because of the complexities in this type of group, a number of communication norms are required: openness (leveling) and a person-to-person relationship with enough mutual trust to enable each person to "tell it like it is."

Team practice can not work if roles talk to roles; a much more personal mutual dependency is required. Influence, communication frequency and leadership should be determined by

the nature of the problem to be solved and not by hierarchical position, educational background or social status.

With respect to leadership, in particular, the teams we have studied relied on the model they knew best—in this case “follow the doctor.” Continued reliance on that model will result in an overemphasis on medical instead of social issues, a lack of shared commitment to decisions (which doctors sometimes interpret as “lack of professional attitude”) and less than complete sharing of information, all of which directly affect the task performance.

### *Norms*

Much of what has been described is reflected in a group’s norms. The teams studied have exhibited several powerful norms:

1. “In making a decision silence means consent;”
2. “Doctors are more important than other team members;” “we don’t disagree with them;” “we wait for them to lead;”
3. Conflict is dangerous, both task conflicts and interpersonal disagreements; “it’s best to leave sleeping dogs lie;”
4. Positive feelings, praise, support are not to be shared;—“we’re all ‘professionals’ here to do a job.”
5. The precision and exactness demanded by our task negate the opportunity to be flexible with respect to our own internal group processes (this may be a carry-over from the hospital operating room environment where the last thing needed is an innovative idea as to how to do things better.

The effects of these norms, and others like them, is to guarantee that a team gets caught in a negative spiral.<sup>11</sup> The norms are those of rigidity, but the complexity of the environment and the task to be done demand flexibility. The frustrating, anxiety-provoking quality of the task places great demands for some place to recharge one’s emotional battery. The team is potentially such a place.

In addition to these specific norms of flexibility, support and

openness of communication, a set of higher order norms is essential. Task uncertainty and environmental changes require that a team develop a capacity to become self-renewing—become a learning organism. Learning requires a climate that legitimizes controlled experimentation, risk taking, failure and evaluation of outcomes. In the absence of norms that support and reinforce these kinds of behaviors, a team will end up fighting two enemies—its tasks and itself.

In other words, a unique connection exists between what a team does (its task) and how it goes about doing it (its internal group processes). At a simple level, the health care analogy would be: if a team is to treat a family as an integrated unit (its task), the team itself must, in many ways, operate as a highly integrated “family unit” (its internal group processes). Without this ability to maintain itself a health team will, like many other “pieces of equipment” eventually burn itself out. In the interim, work continues to get done, but more and more energy is demanded to “move the machine forward.”

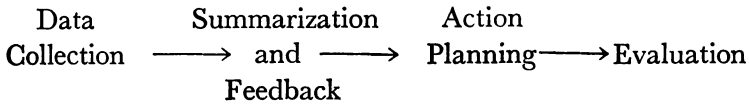
To summarize, the “internal process” issues that have been discussed will occur in any group. They can not be wished away or ignored for long without some cost. Nor are they the result—as is frequently assumed—of basic personality problems. More often team members have difficulty functioning together because of ambiguous goal orientations, unclear role expectations, dysfunctional decision-making procedures and other such process issues.

If a health team is first to survive and second to grow, it must develop an attitude and a capability for building and renewing itself as a team. It can do this first by becoming aware of how its internal group processes influence its ability to function and second by learning how to manage these processes or maintenance needs in a more productive manner.

We turn now to a brief case illustration of an effort aimed at helping health teams move closer to this ideal of becoming self-renewing or learning organisms.

A CASE STUDY OF A HEALTH TEAM IMPROVEMENT EFFORT

Our efforts at helping teams improve their functioning<sup>12</sup> relied heavily upon a simple but powerful model: the action research approach.<sup>13</sup> The basic flow of activities can be depicted in the following manner:



In this setting, the initial activity with a health team involved interviewing each member individually using both open-ended questions and check list ratings. Questions asked related directly to the seven process factors discussed earlier such as team goals, levels of participation, decision-making styles and so forth. These data were then summarized and fed back anonymously to the entire team.

Team members' reactions to the data presented during this feedback session were varied. For some, the result was one of surprise—"I didn't realize people felt that way about this team!" Others were surprised to find many of their own concerns widely shared. Before the feedback session, many people believed they were the only ones experiencing certain difficulties. The most frequent reaction could be characterized as follows: "These problems have been around—under the surface—for a long time. Now they have been collected, summarized and are out on the table for all of us to see."

The teams, in other words, were provided with an image or picture of their present state based on information (feelings as well as facts) collected from the most valid sources available, the team members themselves. As a result of the interview feedback process, teams owned the information (verbatim quotes were used to exemplify a particular issue) and shared the image of their present state—"it's out on the table for all of us to see." These two elements of shared ownership helped to create a heightened desire and commitment on the part of team members to solve their problems.

To cope with the large number of complex problems reflected in the information and to move most effectively into action planning, the health teams had to:

1. Assign priorities to the multiple issues reflected in their data;
2. Decide upon the most appropriate format to use (total group, homogeneous versus heterogeneous subgroups and so forth) to generate solution alternatives;
3. Develop a clear and shared set of change objectives or goals; an image of what a more ideal or improved state would be;
4. Allocate individual and subgroup responsibilities to implement chosen actions;
5. Specify mechanisms and procedures for checking progress (follow-up).

The problem-solving skills, attitudes and norms needed to accomplish the above "process work" were similar to behaviors needed to successfully accomplish "task work." This unique connection between task and process can be clarified with the following example.

A salient problem in each health team concerned their regularly scheduled 90-minute weekly team conference meetings. These meetings represented the one time each week when the entire team met together. The intent was to discuss patient family cases, learn from each other's experiences, work on common problems and the like. The pervasive feeling with regard to these meetings was one of frustration and dissatisfaction. They were dull, a waste of time and a time for some people to "lecture" about their pet topics.

The way the team managed itself (its process) during these meetings in fact made the situation more difficult. The negative spiral to which we referred earlier was operating to drain energy and commitment required to solve patient problems.

The specific action plans developed and subsequent team improvement interventions were, in each case, a product of the

particular issues reflected in the data collected initially from a team. Regardless of the problem, the same action research model, with minor variations, was applied. For example, action plans aimed at improving the team conference meeting included: (a) the formation of agenda planning committees; (b) systems of rotating chairmen to help all team members enhance their skills at running a meeting; (c) designation of observers, on a rotating basis, to help the team evaluate, at the end of each meeting, the impact of its own group dynamics.<sup>14</sup>

Many consultant interventions were aimed at helping a team to solve problems it presently felt; longer run considerations also guided consultant behavior. Whenever feasible, a team was helped to see the connection between what they were doing (their task) and how they were going about it (their internal group process). This expanded awareness helped to develop an attitude (norm) toward change, which legitimized managed experimentation and learning. In other words, if a team is to become self-renewing, it must be willing to experiment in a controlled way—to try new ways of working, evaluate and learn from the consequences of these efforts, and use this new learning in planning and implementing future efforts. On the assumption that the action research approach we used represented a general problem-solving model, we continuously worked to help the teams to adapt this model so that they could apply it when confronted with future problems.

The short time frame within which we worked dictated limited and modest objectives. Short-run changes have been observed and documented in terms of:

1. Greater work productivity, particularly with respect to team conference meetings;
2. Increased clarity of role expectations plus mechanisms for negotiating changes in role behavior as they are needed;
3. Greater flexibility in decision-making;
4. More widely shared influence and participation among all team members.

## IMPLICATIONS FOR HEALTH TEAM OPERATIONS

Based on an understanding of groups in general and our experiences with health teams working in an urban community, several significant lessons are beginning to emerge with implications for the delivery of health care using groups or teams.

1. Some conscious program that helps team members look at their particular goals, tasks, relationships, decision-making, norms, backgrounds and values is essential for team effectiveness. It is naive to bring together a highly diverse group of people and to expect that, by calling them a team, they will in fact behave as a team.

2. Behavioral science knowledge and techniques, developed in a variety of nonmedical settings are relevant and appear to be transferable to organizations involved in the delivery of health care. The action research approach is one such example. It reflects a methodology and set of values that can help a team become a self-renewing organism. In some ways, it demands of a team that it treat itself as a patient, periodically diagnosing its own state of health, prescribing medication, and subjecting itself to the check-ups to insure that the prescription is working. Although this process may require the assistance of a "third party" initially, the "patient team" can learn to do many of the things itself.

3. Ideally, every team member can be a participant in the group's task and an observer of the group's process. At a minimum, such capability for helping teams look at their own working should be built into the training of team leaders.

4. The organizations in which health teams are imbedded will need to develop an internal capability to help groups manage their own process. Outside resources are appropriate to initiate such activities, but internal specialists are needed to provide needed continuity, follow-up and reinforcement.

5. Programs need to be developed that focus specifically on the problems of helping people cope with cultural discrepancies whether these be between a team and its client population



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or between team members; e.g., the professionally based physician and the community based family health worker.

6. Certain team members will need particular leadership skills. If nurses are expected to act as team coordinators, they will need special training. All team members will need to develop membership skills; e.g., listening, collaborating.

7. Although some of this needed training may be accomplished during individual preparation,<sup>15</sup> some training needs to be done with the team as a unit. In addition, more of this training needs to be goal related—e.g., treating a family as an integrated unit—as compared to technique related—e.g., taking histories, doing EKG's. (This does not imply that such skills are unimportant, only that they should be learned in relation to specific goals).

8. The socialization of new team members needs to be examined. Programs need to be developed that in fact orient a new family health worker, for example, to her role as a team member as well as a specialist with particular skills.

9. There is great value in initiating team development activities, of the kind described, at the point of a team's formation. Teams, like individuals, develop their own cultures or personalities. In "older teams" a considerable amount of unfreezing may have to take place before new changes can be tried. Early team development efforts would have several distinct advantages: (a) the period of initial socialization has a significant effect on the team's future development—early experiences set a very strong tone that influence future events; (b) a group can more easily create the kind of culture, norms and procedures it deems useful if it is starting fresh rather than having to "undo" a long history of past experiences; (c) perhaps most important would be the early recognition that the team really has two equally important tasks—to deliver health care and to continuously work to develop and maintain itself as a well-functioning team to improve its services.

The focus of this paper has been upon the working of existing health teams in a community setting where entire families

are "the patient." We have explored some ways in which one might help such a team learn more about its own "internal dynamics" and use these learnings to improve the way it functions in delivering health care.

We will, in all likelihood, see an increasing number of models for delivering health care in which groups of some form play an integral part. The effectiveness of these groups in accomplishing their tasks will be, in part, a function of how well they manage themselves with respect to the "process variables" discussed in this paper.

## REFERENCES

<sup>1</sup> The average team in this center consisted of a full-time internist, a full-time pediatrician, two full-time nurses and four to six full-time family health workers drawn from the community. Available on a part-time basis were a dentist and a psychiatrist, in addition to the back-up support of x-rays, laboratories and the like. A team was responsible for 1,500 families in a particular geographic area.

<sup>2</sup> We pay little attention in this paper to the important question of the organization of which the health team is a part. For an intensive discussion of the organizational issues involved in the delivery of health care see Beckhard, R., *Organizational Issues in Team Delivery of Health Care*, in this volume.

<sup>3</sup> For an excellent and readable description of group process see Schein, E. H., *PROCESS CONSULTATION*, Reading, Massachusetts, Addison-Wesley Publishing Co., Inc., 1969; for a more general introduction to the field of organizational psychology see Schein, E. H., *ORGANIZATIONAL PSYCHOLOGY*, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1965.

<sup>4</sup> For a study of role sets see Kahn, R. N., *et al.*, *ORGANIZATIONAL STRESS: STUDIES IN ROLE CONFLICT AND AMBIGUITY*, New York, John Wiley & Sons, Inc., 1964.

<sup>5</sup> Group practice here means situations in which people are together over long periods of time working on a common task. More temporary groups such as the group formed to do a particular operation in a hospital are not included in the discussion. Even in many temporary groups, such as short-duration task forces or committees, many of the process factors discussed can be observed to be in operation.

<sup>6</sup> For a more detailed preliminary report of activities in this setting see Fry, R. E. and Lech, B. A., *An Organizational Development Approach to Improving the Effectiveness of Neighborhood Health Care Teams: A Pilot Program*, unpublished masters thesis, Massachusetts Institute of Technology, June, 1971.

<sup>7</sup> If one takes a total hospital as a group many similar issues appear. Revens, for example, argues that the central task in a hospital is the management of anxiety. This is analogous to the position we take vis-à-vis a health team. The only difference is that the problems are more visible in the smaller social system

of an ongoing group. See Revens, R. W., *STANDARDS FOR MORALE: CAUSE AND EFFECT IN HOSPITALS*, London, Oxford University Press, 1964.

<sup>8</sup> A useful tool for diagnosing the forces impinging upon a team is called force field analysis. For more detail see Fry and Lech, *op. cit.*; and an article by Lewin, K., in Bennis, W., Benne, K. and Chin, R., *THE PLANNING OF CHANGE*, second edition, New York, Holt, Rinehart & Winston, Inc., 1969.

<sup>9</sup> The notion of a team approach to the delivery of health care may, for example, force a redefinition of the norm of privacy between doctor and patient. The norm may need to be adapted to encompass team and patient.

<sup>10</sup> Many organizations are realizing the needs for such fluid role relations. A job is now viewed as a "man in action in a particular situation at a particular moment." Such "job descriptions" must be constantly renegotiated and updated to account for both changes in the man and the situation.

<sup>11</sup> It is in this regard that our thinking is similar to Revens'. The ineffective management of inherent anxiety results in more anxiety creating a negative feedback loop and a self-reinforcing downward spiral. See Fry and Lech, *op. cit.*

<sup>12</sup> Initial efforts at intervening into two health teams are reported in detail in Fry and Lech, *op. cit.* We have to date completed initial interventions with six health teams. Similar activities are planned for other teams in the future as well as follow-up activities to reinforce initial efforts. Four of our students—Ron Fry, Bern Lech, Marc Gerstein and Mark Plovnick—have worked closely with us in these efforts.

<sup>13</sup> For a description of this model and its applicability in a wide variety of situations see Beckhard, R., *ORGANIZATION DEVELOPMENT: STRATEGIES AND MODELS*, Reading, Massachusetts, Addison-Wesley Publishing Co., Inc., 1969.

<sup>14</sup> In several cases, these observers were part of the next agenda-planning committee. The data collected by the observers, in other words, were quickly used as an input into the next action planning phase.

<sup>15</sup> It is clear that existing educational and training institutions—medical schools, nursing schools, teaching hospitals—will need to bear part of this responsibility. In addition to the content areas of psychology, social psychology, sociology and the like, increasing emphasis must be placed on such areas as group dynamics, organizational behavior, social intervention and the theory and process of planned change.

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