

Interprofessional Perspectives on Teamwork in Health Care: A Case Study

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DURING THE LAST TWO DECADES THE HEALTH CARE team came to be viewed as an integral part of health care delivery and the sine qua non for getting tasks done. Yet much of the literature on teamwork has remained mainly prescriptive and has rarely been analytical. Anyone familiar with health care literature must largely assume that interprofessional teamwork is alive and doing well.

The purpose of this study is to reexamine and challenge the literature's presentation of the "interdisciplinary team" concept. (For a typology of "team," see Petrie 1976 and Schmitt 1981. In this study "interprofessional" and "interdisciplinary" team are used interchangeably and refer to a phenomenon of practice that includes a physician and a nurse.) The study explores the assumption that a phenomenon of practice variously called an "interprofessional" or "interdisciplinary" team exists, and is an easily identifiable, well-defined, and bounded unit. What is known is that there exists a certain arrangement between health professionals who practice together. This paper proposes that there is a discrepancy between nursing's and medicine's views and expectations of "interdisciplinary team" and that this has important consequences for the viability of the interdisciplinary model of practice as it is portrayed in the literature. (For a historical review of the

ideological nature of teamwork, see Brown 1982). Within the inter-professional team this discrepancy is expressed in *structural* terms, i.e. the allocation of roles and status, as well as in *normative* terms, i.e. the different values and norms of medicine and nursing. The difference in structural and normative expectations of the two professions, to some degree, create a meeting of two "cultures." Team care, therefore, may be more accurately termed an intercultural rather than an interprofessional venture (Lewis 1968). The aim of this study has been not to observe "teams" in practice, but to explore the ways in which leaders in nursing and medicine understand and define the team concept and its purposes and goals, i.e., its structural and normative aspects.

To date no adequate theory of team in health care has been formulated, empirical data are scarce, and the concept of teamwork itself has not been sufficiently questioned and/or understood. In 1955 Garrett noted that the notion of "team approach" to health care has been so often repeated that its validity has been unquestionably accepted while its meaning has remained obscure. Much has changed in the last three decades in health care provision, and the rationale originally advanced for teamwork has become more enticing than ever. It has been argued that advances in medical knowledge and technology, the increasing number of subspecialties among health care providers, manpower shortages in some of the highly trained professions, and the broadening concepts of health and illness have all served as an impetus to the development of the interprofessional team approach (Lewis 1968; Kane 1975; Nagi 1975; Ducanis and Golin 1979; Spitzer and Roberts 1980; Gardner and Fiske 1981).

The interdisciplinary team approach to health care provision has been advocated by medicine and nursing. In 1978 the Institute of Medicine (IOM) recommended teaching the "team approach" to care delivery in medical schools; in 1980 the IOM's recommendations met with the support of the American College of Physicians. In the same year the American Nurses' Association identified "collegial, collaborative joint practice" as the ideal approach for the development of working relationships between nursing and medicine.

However, the goals of nursing on the one hand, and those of medicine on the other, were and are fundamentally different. Medicine has been seeking to define the expanding nursing role in terms of physician-extendors with physicians retaining the leadership position

within a team (Lewis 1968; Pellegrino 1972; Spitzer and Roberts 1980; Schmitt 1982). Nurses view "teams" as vehicles through which to apply their particular knowledge and treatments to direct patient care, and as means for achieving greater status and autonomy (Bullough 1976). Consequently, nursing's view of teamwork has evolved around the democratic ideals of equality, decentralized authority, and flexible task-oriented leadership (Aradine and Hansen 1970; Leininger 1971; Ames and Perrin 1980; Shumaker and Goss 1980; Brown 1982). The discrepant expectations and perceptions of the health care providers vis à vis the interprofessional teamwork are played out on a number of different levels including intrapersonal identity ambiguity (Wise et al. 1974; Bates 1975; Ballassone 1981), interprofessional conflicts related to professional dominance and socialization (Coser 1964; Strauss et al. 1964; Bates 1970; Friedson 1970; Banta and Fox 1972; Lynaugh and Bates 1973; Dachelet and Sullivan 1979), institutional-organizational arrangements (Beckhard 1972; Wise et al. 1974; Weisbord 1976; Tichy 1977), and governmental policies regarding the health care professions (Abdellah 1976; Bullough 1976; Henderson 1981; Fagin 1982). Despite the potential pitfalls with which the road to teamwork is paved, the literature for the most part portrays teams as intrinsically desirable. At the same time the concept of team itself remains "largely a matter of faith" (Halstead 1976).

What Is a Team?—Assumptions

While the interprofessional team approach in health care has been widely accepted, no operational definition of team has yet been offered nor have the characteristics of such a social group been adequately described and/or analyzed. The literature overflows with the assumptions regarding the structural and the normative characteristics of interdisciplinary teams. Structurally, a team seems to evoke the image of a small, bounded unit, with set goals and objectives, and to include individuals with a minimum of task and knowledge overlap. Such a group is expected to have a decision-making capability and a system of communication involving some face-to-face interaction. The corresponding normative characteristics overwhelmingly identified in the literature convey the image of teams being clearly defined and identifiable with specific goals which are common to all members, and with a

clear separation of roles and professional domains. The model of communication within the team structure is expected to be one of *collaboration*. The decision-making structure is expected to allow for decentralized authority with either flexible and changeable leadership or with a fully egalitarian system of authority. Given the present state of the art in research on interdisciplinary teamwork, the structural and normative characteristics of team must, for the most part, remain within the domain of faith. (Notable exceptions include Feiger and Schmitt 1979.) Yet these must be explored if we are to decide whether this interprofessional team formula is an adequate and/or viable concept for guiding action in health care. It has, therefore, been the purpose of this investigation to determine to what extent the structural and the normative characteristics prevalent in the literature are observed and/or perceived by those who by virtue of their position in a health care institution maintain and/or create interdisciplinary teams. This study also seeks to assess the degree of concordance between the structural and the normative axes along which interdisciplinary teams are thought to have been organized.

Data and Method

This study investigated the nature of an arrangement between different health care providers described as an interdisciplinary or interprofessional team. Because most teams operate within the framework of larger organizations, this study sought to understand the nature of teamwork from the perspective of the administrative leadership of an institution within which interdisciplinary teams are assumed to have been in existence. The site of this study is a large medical center and teaching hospital considered to be an institution highly supportive of the interdisciplinary team concept. Twelve interviews with senior faculty of this large teaching hospital were conducted in order to gain some insight into the nature of that arrangement between different health care professionals referred to as a "team." Eleven of those interviewed are department heads of nursing and of medicine (six and five respectively), and one is the head of the outpatient unit of general medicine. These individuals were chosen because in their positions they represent, at least theoretically, a link between the administrative structure of their respective professional schools (nursing and medicine), the practice setting, i.e., the hospital, and the clinical structure of

practice for which they are responsible. In their positions they should be well suited to observe, identify, and maintain interdisciplinary teams if they exist, and to create them if they do not exist but are desired.

Generally, one of the disadvantages of interviews is that the fieldworker becomes aware of the characteristics studied only from the point of view of the respondents and is, therefore, precluded from checking the actual quality of the characteristics. In this specific case, however, the folk approach which the interview facilitates was precisely the purpose of the study, i.e., to obtain the descriptions and/or judgments concerning the nature of interprofessional teamwork which members of a social group (department heads) view as culturally (professionally) appropriate and valid.

The interview guide was developed to find out how a team comes into being, how it is structured, how it functions, and how the organization within which it exists affects it. There were two sections to each interview. The first dealt with the informants' involvement in teamwork either personally or in an administrative capacity. The questions solicited the informants' definition of teamwork, its purpose and *raison d'être*, the existence or lack of administrative support for team practice, the means of evaluating teamwork, and other information. The second section dealt primarily with the organization and function of the team itself, as well as with the impact of the larger organization on it. Each interview was approximately 45 minutes long, and all of them were tape recorded. The interviews were conducted from October through December of 1981.

Discussion of Results

What Is a Team?

Perhaps the only thing that all those interviewed agreed upon was the definition of a team, with its most salient characteristics being:

- a. a group of people with different expertise;
- b. working together;
- c. to provide patient care.

Such a definition, however, does not clearly define a reason for teamwork. Based on the above characteristics, a hospital itself is a team, and yet

teamwork seems to mean more than simply a conglomeration of people for the provision of health care. One department head of nursing did not feel comfortable using the word team because “of its confusing meaning.” This informant applies a strict requirement of collaborative practice as a necessary characteristic of interprofessional teamwork. Another informant eloquently and comfortably described his own involvement in team research whose members were M.D.s and Ph.D.s—all more or less peers in education and at least self-perceived status. However, when asked to define a team composed of *health care providers* of different professions, and more precisely of nursing and medicine, he responded:

It is a very foreign word to me. . . . I do not use the word team. I will tell you from the outset that team seems to be the word which started from the nursing discipline. I think it is a very important distinction, too, because medical people and the nursing people will come together to meet at the same time, over the same materials, in the same place, and one is talking about going to a team meeting and another about going to a committee meeting.

The reasons which the informants offered in explaining the existence of interprofessional teams or for the use of the notion of teamwork were varied. Almost all would have agreed that teams were introduced because no single individual can provide full patient care. Some felt that “by definition you have to have a team, or at least a group,” and that, if for no other reason than pure frustration, that group will eventually learn to act as a team. Others felt that teams “help” physicians with their time, and that, particularly in ambulatory care, teams have been shown to be cost-effective. Still others, most notably a medical department head, felt that the concept of team was “developed by nurses in a very self-serving way—nurses can join teams [ongoing projects] and demand equal considerations [but] do not initiate action on their own.”

Another physician informant felt that

the frequent use of words like team and collegiality comes about when these kinds of organizational characteristics are desired but are absent. The word is being used to bring the desirability of that to the consciousness of those involved, or perhaps in some way to force that kind of operating principles.

Clearly, these physicians view teamwork as a nursing concept, beneficial primarily to nursing and used to "usurp" the traditional authority of medicine in health care provision (see also Brown 1982). Nursing, on the other hand, views medicine as accepting of interprofessional teamwork only when it is, in one way or another, imposed from the outside. For example, a nursing department head was quick to point out that while teamwork is necessary for the provision of good patient care in her department, it is also mandated by the Joint Commission for Accreditation of Hospitals which requires that department to have interdisciplinary teams, and a written documentation of this must exist for an audit. The informant volunteered that while her discipline has had a long history of team practice and the recognition of the role of small interdisciplinary groups in management of patient care, the recent trend within this discipline of emphasizing the biophysiological component of illness appears to be having a profound impact on the future of interdisciplinary teamwork. Such a trend would seem to negate the contribution that nursing can make in psychosocial management of illness, and emphasizes the physicians' attitude of the "Lone Ranger" approach to diagnosis and treatment. Another nursing department head pointed out that while the ambulatory setting within her discipline has been quite favorable to teamwork, it may not have been a sheer coincidence that patient care projects funded through particular foundation grants required that nurses be included in medicine's projects and that physicians be included in nursing's.

The accusations of self-serving behavior on the part of medicine and nursing are perhaps not new. What appears to be at the center of this issue, however, are the contradictory visions of the two "cultures," i.e., medicine and nursing vis à vis team. Medicine emphasizes the status quo of its traditional authority and inherently hierarchical mode of organization and function. Nursing, on the other hand, stresses a more egalitarian vision of power relations with collaboration and peer cooperation as prerequisites for team care provision.

It is appropriate at this point to introduce M.G. Smith's (1980:18-19) definitions of power and authority, where the latter is defined as "the right to make a particular decision and to command obedience," and the former as "the ability to act effectively on persons or things, to take or secure favorable decisions which are not of right allocated to individuals and their roles." Traditionally in health care, both power and authority rested with medicine. While authority still rests

primarily with medicine, power has been both demanded by and delegated to other health care providers, with nurses being in the forefront. The conflict in teamwork, and perhaps in the larger inter-professional relations between the two "cultures," comes about from nursing seeking shared authority. Historically, nursing has secured power (Stein 1967). Now, it is seeking to legitimize the right to exercise it within the diagnostic and the therapeutic domains of health care. It is, therefore, not surprising that resistance to teamwork need not always come from medicine alone in its attempt to retain authority, but also from nursing in its attempt to gain a share in it. Medicine may be quite agreeable to the concept of teamwork if given an unconditional captaincy; as one medical department head put it, "It is hard for a physician to accept working for someone who is not a physician." On the other hand, one nursing department head thought nursing should not too eagerly advocate teamwork because as a profession it is too young and fragile to safely subject itself to team structure and function before the question of team leadership is resolved. This informant sees teamwork as a political problem where nursing demands a share of professional authority and medicine will not relinquish it.

Becoming a Team Member

How does one become a team member? It is a difficult question for it deals with the very concept of team. Is it a group of people who are brought together and called a team or is it a group of people who come together voluntarily on an ad hoc basis and may retrospectively be viewed as behaving in a team-like fashion, or yet, is it some structural and/or functional arrangement falling in between the two? In only two cases did my informants report that individuals are actually designated as team members. A physician and a nurse, department heads, both of whom represent the same discipline, informed me that "teaming" is a programmatic and an administrative decision in their department. Individuals are assigned to structured group-teams whose membership is identifiable but not necessarily inflexible, particularly for inpatient teams. The second case involved an ambulatory unit in which all providers are "teamed up" administratively. Interestingly enough, in the first of these cases, interdisciplinary teaming is mandated by the Joint Commission for Hospital Accreditation, although teams in this particular discipline antedate such a mandate. In the second instance, health care projects that constitute a sizable portion of de-

partmental income require interdisciplinary interaction, if not necessarily cooperation.

In only one case did the informants (medical and nursing heads of the same specialty area who came to this conclusion independently) refer to team membership retrospectively. The team to which they referred was not administratively structured, individuals were not assigned to it and designated as team members, and the word team was never used, yet the informants felt that this group of individuals, representing different professions and working together to solve common problems around patient care, functioned as a team.

The only common denominator in the remaining cases is that individuals are not administratively designated as team members and are only assumed or expected to behave as a team. It is apparent that many informants in this last category use the word team freely to discuss the kinds of organizational characteristics which they deem desirable but which, in fact, may not exist.

Other aspects of team organization were investigated. One of them dealt with the role of team members in the decision-making process regarding team composition. All of the informants felt that the ultimate decision lies with the respective departmental heads, but most felt it would be unwise to impose new members upon the existing ones. One medical department head, however, strongly felt that

people do not have much to say about team membership, because this is not a democratic process, it is more [that] we have a job to do, and if people have an argument that makes sense we should listen to them. But team is not a social unit, it is a program unit, a business. I don't look at it that everybody has to be happy.

Most informants felt that both nurses and physicians have equal input to the decision-making regarding team composition, but that the opportunity for physicians to interview nurse-team members is greater due to higher rates of turnover among the latter. Only two nursing heads felt strongly that nursing's input to team composition is minute, and that this is a reflection of the traditionally lower status granted to nursing.

Decision Making

One aspect of decision making within a team has often been viewed in the literature as a matter of morality rather than a matter of strategy.

It is the aspect of decision making that relates to the structure of roles and authority within teams. It has been generally assumed that team members should, if they in fact do not, act as peers and equals within the team setting. The notion of democracy, while most often not well specified, recurs in definitions of teamwork. However, most interdisciplinary team members have different formal statuses and ranks in a social establishment. When staff and line statuses tend to divide an organization, as they do in this teaching hospital, performance of teams may tend to integrate the divisions. At the same time, it is apparent that teammates must cooperate and that "in proportion to the frequency with which they act as a team . . . [they] tend to be bound by rights of what may be called 'familiarity' " (Goffman 1959:83). The conflicts between teammates regarding decision-making structure may be created by that paradox which, on the one hand, allows familiarity between members, but, on the other, integrates the organizational divisions of status and rank into the team. Those of higher status and rank may wish on occasion to emphasize their position, minimizing the familiar, while those of lower rank are more likely to reject the status integration into the team and emphasize the familiar or collegial as the condition necessary for good performance. In health teams this paradox tends to exist along the professional lines.

Most of my informants felt that there definitely is a position of leadership on a health care team, but not all agreed on who should fill this role and/or of exactly what this role entails. Only one medical department head (particularly well versed in the interdisciplinary team literature) appeared to have been uncomfortable with the question of leadership. He felt that a team has responsibility for issues of care provision, that it is guided by guidelines of practice which "hopefully is collegial," and that, consequently, there is no need for a position of leadership. Another medical department head felt strongly that there definitely needs to be *one* leader, and that the position should be purely administrative, requiring appropriate medical and organizational skills. This informant felt that many health care professionals may qualify to fill the leadership role. The remaining medical and sole nursing heads agreed that a leadership position should not be discipline oriented, but should be determined primarily by individual qualifications and the immediate task needing attention.

It is interesting that the physician-informants did their utmost to

deemphasize the role of physicians as team leaders. In contrast, the majority of the nurse-informants felt that, while nursing tends to see collective responsibility for joint practice, there is an (often) unspoken assumption on the part of medicine that physicians are the leaders. Indeed, one informant reported much conflict over the "who is in charge?" issue. The department in which this nursing head practices is divided into units each with its own clinical director, always a physician. The question, however, is what does "in charge" mean? Since the medical center's authority structure is functionally or discipline oriented, physicians are not in charge of nursing, social work, or other professionals who are not physicians. This functional structure of the medical center is emphasized very strongly by all the department heads and is highly valued by the nurse-informants. Yet, nursing, by its very position, is unequal as is evident from the existence of covert antagonisms between medicine and nursing over patient assignments, which are under medicine's control and, thus, determine nursing's ability to generate its own income.

The difficulties in realigning the boundaries of professional domains are clearly evident to most department heads and appear to be greatly compounded by potential economic and social consequences.

Team and the Institution

While many use the word team and discuss the team-related concepts, interdisciplinary teams as administrative structures are, for the most part, absent in the practice setting of this medical center. There appears to be relatively little interest on the part of hospital administration in the concept of interdisciplinary teamwork. As one department head put it, "No one ever thinks about it." Yet some informants felt that administrative concern for teamwork exists. This concern, however, is not manifested in any concrete terms. Philosophically, teams may be perceived as desirable by those in nursing and medical administration since they have come to accept that teams hold potential in expanding teaching and research opportunities as well as benefiting patients. While, conceptually, teamwork may be desired in the medical center, it has not been demonstrated organizationally. For the most part, the informants appear to feel that organizational procedures and administrative directions regarding teamwork are unnecessary and potentially cumbersome, and that teams can be established simply by trial and

error. The prevalent feeling was: If it works, why think about it? The questions, however, are: Does teamwork work, does it work as well as it should and could, and even what exactly is it? It is crucial to determine what the structure of teamwork is in relation to its social context and how it functions within that setting.

Perhaps the single common denominator reported by all the informants is the lack of any structure to teamwork and a total absence of organizational directives regarding teamwork. With minor exceptions discussed above, all department heads agreed that there are no designated and/or administratively sanctioned teams in this practice setting.

Whether or not teams are designated as such or are simply perceived to exist by the department heads, they are never evaluated for their performance as a team. Informal intrateam evaluations are said to be encouraged, but are not required. Programs evaluate individuals, not team members, and the emphasis is on improving individual performance. Perhaps not surprisingly, no one claims responsibility for a product or service which a team is expected to provide since no one really knows what a team is, how it should work, and what its product is. Despite this, the informants tend to believe that teams are benefiting the patients.

Some of the informants believe that at the heart of the interprofessional struggles lies the very structure of the medical center and the respective professional schools. The existing governance system does not encourage and/or facilitate interprofessional-interdependent behavior. Loyalties are departmental and disciplinary, rather than institutional or goal oriented; performance evaluation emphasizes the individual rather than the interdependent group/team; decision making and authority are functional, and budgets tend to flow through the schools and the departments. Few informants have expressed hope that this situation can be ameliorated by recent changes in the governance of the hospital that provide for the organization of patient services into interdisciplinary functional units with budgets of their own. Informants, especially those in nursing, are apprehensive that the change may diminish nursing's autonomy over nursing practice and education.

The medical center activity and its administrative machinery do not seem to be connected, at least where interdisciplinary teamwork is concerned. The reasons for this are multiple and have to do with nursing's and medicine's traditionally separate and unequal tasks,

identity and governance. As a result of this disconnectedness of health care activity and administrative machinery, on the one hand, and of nursing and medicine, on the other, there is no organizational payoff for face-to-face interdependent behavior without which teamwork does not exist.

Conclusion

The concept of team allows us to think of performances that are given by one or more than one performer; it also covers another case. Earlier it was suggested that a performer may be taken in by his own act, convinced at the moment that the impression of reality which he fosters is the one and only one reality. In such cases the performer comes to be his own audience; he comes to be performer and observer of the same show (Goffman 1959:81-82).

For the past thirty years the health care literature has been presenting a concept of interdisciplinary team which, it claimed, reflected the reality of the working arrangements between different health care providers, most notably between a nurse and a physician. Team, as presented in the literature, possesses certain structural and normative characteristics which must be concordant. This paper challenges the notion of "interdisciplinary" or "interprofessional" teamwork as reflecting more the impression of reality which some health care providers wish to foster than the reality itself.

Team approach to teaching and health care delivery has been advocated by medicine and nursing alike, with the overall goal of interprofessional teamwork being the improvement of patient care. What has become fairly obvious from discussions with informants is that the individual and the overall professional goals of nurses and nursing, and of physicians and medicine, vis à vis teamwork are disparate and contradictory. As one informant has put it, "Conflict comes over each other's (physician, nurse) expectations of how each will function" in a team. Given the discrepancy between nursing's and medicine's views and expectations of interdisciplinary teams, it is not surprising that the structural and the normative characteristics ascribed to team in the literature are in dissonance in practice.

Few of the structural characteristics of team which the literature identifies were also observed by the informants:

1. Rarely did the informants refer to teams as identifiable, bounded units with set goals and objectives. "Teaming" in this study setting does not, for the most part, reflect a programmatic or administrative decision, but rather an ad hoc structure which, once disbanded, may or may not rejoin again.
2. Individuals are generally not designated as team members, but informally may be expected to perform in a teamlike fashion.
3. There appears to be much conflict over the decision-making structure and the position of leadership. While, conceptually, teamwork seems to be desirable to the informants, structurally it is rarely evident.
4. This is further supported by the fact that teams, even if perceived to exist by the informants, are not evaluated for their performance as teams, nor are the providers evaluated in the context of their presumed team membership. The general absence of structural characteristics of an interdisciplinary team in this setting may, in part, be attributed to the structure of the medical center and its professional schools. One should expect that when loyalties are disciplinary, and goals are discrepant, and where there is no organizational payoff for interdependent behavior, teams, as structural units conceived in the literature, are not likely to be present.

If the expectations of the professionals are in dissonance, one should expect the normative characteristics of teamwork to reflect that dissonance and the incongruities between the structure and the norms. Indeed, the informants found it difficult to define clearly and identify the interprofessional teamwork. There appeared to be much confusion and conflict over professional roles and domains, and over the position of authority. What clearly emerged in this study is that goals are neither team/member nor profession specific and/or common. The goals vis à vis team appear to be discrepant on two levels, one level being medicine versus nursing, the other, individual versus overall professional. On the individual level, physicians see nurses as extenders of their roles and as helpers. Nurses, on the other hand, view a team as

providing access to direct patient care, and as means to gain status. On the overall professional level, medicine's goal is to maintain authority over health care delivery while relegating some tasks to other providers. In this way the individual and the professional goals are not discrepant. The overall professional goal of nursing is to gain a share of authority and to improve the status of the profession. Thus, the individual and the professional goals vis à vis teamwork in nursing may come into conflict, as individual practitioners struggle to maintain teams to further their goals, yet, on the administrative levels, teamwork may not be perceived as desirable for this young and fragile profession before a degree of authority is secured through perhaps political and legislative means. The conflicting visions and goals of the two professions accentuate themselves clearly vis à vis the interprofessional team that creates and demands the atmosphere of familiarity, yet integrates into the team the social and cultural divisions of status and rank between those providers otherwise expected to be bound by rights of familiarity.

The goals and expectations of nursing and of medicine are often contradictory, yet they are not necessarily incompatible with a working relationship. This study does not question the possibility of a viable and effective arrangement between different health care providers, but rather the existence and the efficacy of a collaborative model of interprofessional teamwork which the literature has come to accept without much question. It is crucial to recognize and understand these "cultural" differences between the two professions as a first step in dealing with the problems of interprofessional relations.

References

- Abdellah, F.G. 1976. Nurse Practitioners and Nursing Practice. *American Journal of Public Health* 66:245-46.
- American College of Physicians. 1980. The Institute of Medicine Report: A Manpower Policy for Primary Health Care. *Annals of Internal Medicine* 92:843.
- American Nurses Association. 1980. Nursing: A Social Policy Statement. Kansas City.
- Ames, A., and J.M. Perrin. 1980. Collaborative Practice: The Joining of Two Professions. *Journal of the Tennessee Medical Association* 73:557-60.

- Aradine, C.R., and M.F. Hansen. 1970. Interdisciplinary Teamwork in Family Health Care. *Nursing Clinics of North America* 5:211.
- Balassone, P.D. 1981. Territorial Issues in an Interdisciplinary Experience. *Nursing Outlook* 29:229-32.
- Banta, D., and R. Fox. 1972. Role Strains of a Health Care Team in a Poverty Community. *Social Science and Medicine* 6:697-722.
- Bates, B. 1970. Doctor and Nurse: Changing Roles and Relations. *New England Journal of Medicine* 283:129-34.
- . 1975. Physician and Nurse Practitioner: Conflict and Reward. *Annals of Internal Medicine* 82:702-6.
- Beckhard, R. 1972. Organizational Issues in the Team Delivery of Comprehensive Health Care. *Milbank Memorial Fund Quarterly* 50:287-316.
- Brown, T. 1982. An Historical View of Health Care Teams. In *Responsibility in Health Care*, ed. G.J. Agich. Boston: D. Reidel.
- Bullough, B. 1976. The Law and the Expanding Nursing Role. *American Journal of Public Health* 66:249-54.
- Coser, R.L. 1964. Alienation and the Social Structure: Case Analysis of a Hospital. In *The Hospital in Modern Society*. ed. E. Friedson. Glencoe, Ill.: Free Press.
- Dachelet, C.Z., and J.A. Sullivan. 1979. Autonomy in Practice. *Nurse Practitioner* 4 (March/April):15-22.
- Ducanis, A., and A. Golin. 1979. *The Interdisciplinary Health Team*. Germantown, Md.: Aspen Systems Corp.
- Fagin, C.M. 1982. Nursing as an Alternative to High-cost Care. *American Journal of Nursing* 82 (January):56-60.
- Feiger, S.M., and M.H. Schmitt. 1979. Collegiality in Interdisciplinary Health Teams: Its Measurement and Its Effects. *Social Science and Medicine* 13:217.
- Friedson, E. 1970. *Professional Dominance*. New York: Atherton Press.
- Gardner, H., and M.S. Fiske, 1981. Pluralism and Competition: A Possibility for Primary Care. *American Journal of Nursing* 81 (December):2152-57.
- Garrett, J.F. 1955. Social Psychology of Teamwork. In *Medical and Psychological Teamwork in the Care of the Chronically Ill*. ed. M.R. Harrower. Springfield, Ill.: C.C. Thomas.
- Goffman, E. 1959. *The Presentation of Self in Everyday Life*. New York: Doubleday.
- Halstead, L.S. 1976. Team Care in Chronic Illness: A Critical Review of the Literature of the Past 25 Years. *Archives of Physical Medicine and Rehabilitation* 57:507-10.

- Henderson, B.J. 1981. The Health Care Delivery Team: A Plan That Needs A Push. *Canadian Medical Association Journal* 124:83-84.
- Institute of Medicine. 1978. *A Manpower Policy for Primary Health Care*. Washington: National Academy of Sciences.
- Kane, R.A. 1975. *Interprofessional Teamwork*. Manpower Monograph No. 8. Syracuse: Syracuse University Press.
- Leininger, M. 1971. This I Believe: About Interdisciplinary Health Education for the Future. *Nursing Outlook* 19:787-91.
- Lewis, C.E. 1968. The Physician as Care Team Leader. *Group Practice* 17:20.
- Lynaugh, J.E., and B. Bates. 1973. The Two Languages of Nursing and Medicine. *American Journal of Nursing* 73 (January):66-69.
- Nagi, S.Z. 1975. Teamwork in Health Care in the U.S.: A Sociological Perspective. *Milbank Memorial Fund Quarterly/Health and Society* 53(1):75-91.
- Pellegrino, E.D. 1972. The Changing Matrix of Clinical Decision-Making in the Hospital. In *Organization Research on Health Institutions*, ed. B.S. Georgopoulos. Ann Arbor: University of Michigan Press.
- Petrie, H.A. 1976. Do You See What I See? The Epistemology of Interdisciplinary Inquiry. *Journal of Aesthetic Education* 10:29-43.
- Schmitt, M.H. 1981. Central Issues in Successful Team Research Efforts. Third Annual Conference on Interdisciplinary Health Teams, Kalamazoo. (Unpublished.)
- . 1982. Working Together in Health Care Teams. In *Life Cycle Group Work in Nursing*, ed. E.H. Janosik and L.B. Phipps. Monterey, Ca.: Wadsworth.
- Shumaker, D., and V. Goss. 1980. Toward Collaboration: One Small Step. *Nursing Health Care* 1(4):183-85.
- Smith, M.G. 1980. *Government in Zazzau: 1800-1950*. New York: Oxford University Press.
- Spitzer, W.O., and R.F. Roberts. 1980. Twelve Questions about Teams in Health Services. *Journal of Community Health* 6:1-5.
- Stein, L.I. 1967. The Doctor-Nurse Game. *Archives of General Psychiatry* 16:699-703.
- Strauss, A., L. Schatzman, D. Ehrlich, R. Bucher, and M. Sabshin. 1964. The Hospital and Its Negotiated Order. In *The Hospital in Modern Society*, ed. E. Fredson. Glencoe, Ill.: Free Press of Glencoe.
- Tichy, N.M. 1977. *Organization Design for Primary Health Care*. New York: Praeger.
- Weisbord, M.R. 1976. Why Organization Development Hasn't Worked (So Far) in Medical Centers. *Health Care Management Review* 1 (Spring):17-28.

Wise, H., R. Beckhard, I. Rubin, and A. Kyte. 1974. *Making Health Teams Work*. Cambridge, Mass.: Ballinger.

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