

The organisational context for teamwork: Comparing health care and business literature

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Abstract

Teams are a significant tool for promoting and managing change. There are shared definitions of teamwork in the literature, and agreement on general benefits and limitations of working in teams. However, the historical development of teamwork differs between health care and the business environments of manufacturing and service industries. The impact of the organisational context on teamwork appears to differ most, when literature from the two environments is compared. As a result, there are specific issues that are unique to the development and implementation of health care teams. This article summarises the unique team structures and the issue of professionalisation in health care teams, while recommending that team members acknowledge their professional differences and focus foremost on meeting patient needs.

Introduction

Currently, quality health care depends on a wide range of skilled professionals collaborating effectively together. Health care professionals need to continually improve the quality and efficiency of patient services in an environment of constant change. Real improvement requires change of the systems in which health care is delivered. Highly skilled clinicians require appropriate and well-designed organisational structures to deliver the best quality care (Klein 1998). Systems change is often perceived as threatening to the status quo, and must therefore be carefully managed to achieve optimum outcomes.

Teamwork has become an essential tool of quality management, which links efficient organisational practice with high-quality patient care. Teams are one of the most effective ways of integrating individual patient concerns with the bigger organisational perspective, while maximising the diversity of the health care workforce. Therefore,

teams are important in both managing and promoting change. However the '[ability] to work as part of a team within a complex [health care] organisation...is much talked about but little studied' (Buchan 1998, p S66).

Effective teams have been promoted as an important means of enhancing organisational performance in business management. Often, literature from the business environments of service and manufacturing industry is generalised to health care without taking account of the differences between the organisations. Jayasuria and Sim (1998) who studied strategic planning, advised against extrapolating findings from business to health care. They highlighted the uniqueness of the variety of health care output indicators (as opposed to business profits and growth), the divergent group of stakeholders (trustees, management, government) and the professional hierarchies.

This article will compare the development of teams in both business and health care literature to emphasise the instrumental role of the organisational context in shaping health care teams. A consensual definition of teamwork will be offered. Further, a discussion of the benefits and obstacles to teamwork will be discussed broadly before the implications for health care environments are highlighted.

Historical context

The importance of knowledge and service industries has increased in response to a continuing technology and information explosion. The information technology infrastructure has assumed many traditional managerial roles and functions. Therefore, organisations are moving towards flatter and more participative management structures where workers receive sufficient information to make effective decisions about their work (West 1994). Task complexity has increased and challenged traditional methods of work specialisation as more information has become available to each worker (Sundstrom, De Meuse & Futrell 1990). Organisations have enhanced their customer focus to become more responsive within competitive and deregulated markets where there are scarce resources (Syer & Connolly 1996).

For these emerging organisations to work well, enhanced communication systems have been required for responsible interdependent decision-making. Generally, teams have accommodated different perspectives and generated workable solutions (Wenzel 1995). Teams have also responded quickly to customer needs and facilitated organisational change (Fanning 1997). As a result, there are increasing recommendations for effective teamwork in most organisations (Lawler 1993; Syer & Connolly 1996).

Development of teams

Over the last three decades, teams have developed to meet the changing and complex nature of organisational activities. Sundstrom, De Meuse and Futrell identified four categories of teams: production/service, advice/involvement, project/development, and action/negotiation.

Initially teams were created at the production level to generate products or services, often with little involvement of managers, support or office personnel. Employees decided on their division of labour to meet defined output quotas. These teams were commonly found in commercial airlines, assembly, construction, mining and sales environments.

During the 1980s quality circles evolved as an employee initiative, to involve people from different work areas in problem-solving of quality and productivity problems. Although these teams did make decisions and advise management, their success was often limited because they did not have sufficient responsibility to enforce the recommended changes (Pearson 1992). Later, project/development teams of white collar workers collaborated on assigned or original projects. These teams focused on innovation rather than implementation, and maintained a breadth of autonomy and an extended life span (Sundstrom, De Meuse and Futrell 1990). Teams that focused on action/negotiation were commonly composed of highly-skilled and specialised people cooperating in brief performance events. These teams often performed management functions through integrating ideas and activity across different functional areas (Mohrman & Mohrman 1997).

In comparison to the disempowering nature of quality circle teams, self-managed work teams evolved during the 1990s in finance, business and manufacturing environments as perhaps a fifth category of teams (Dumaine 1990). Cohen and Ledford (1994) described a self-managed work team as a group of interdependent individuals with sufficient autonomy and responsibility to manage a substantial but unique task-based component of the whole process. Team-members were multi-skilled, so they could move through all the roles/jobs (Pearce & Ravlin 1987). Participative goal setting and individual and team-based feedback were used to minimise the team's variance from their goals (Pearson 1992).

Health care context

Similar trends have been described within health care environments. Social and economic changes, together with enhanced medico-technical developments have influenced the evolution of health care (Loxley 1997). Health care professionals have been required to integrate resource parameters into clinical decision-making as a consequence of increasing pressure to articulate the rising costs of clinical activity. Resources need to be focused where they add most value to the patient (Hastings 1997). Further, rapid technological advances have led to greater complexity and specialisation of health care. As a result, there are risks of fragmented care with more new services and specialisations and a greater need for collaboration. The collective knowledge and skills of health care professionals needs to be maximised to meet the increasing complexity of patients' need (Loxley 1997; Headrick, Wilcock & Batalden 1998). Teams therefore need to include the contributions and perspectives of many specialists, in order to enhance the quality of patient care and clinical outcomes (Horwitz 1970; Snyder 1981; Porter-O'Grady 1997; Firth-Cozens 1998; Rissel, Holt & Ward 1998).

Health care teams have traditionally delivered coordinated patient care (Kane 1975; Griffin 1996; Harber & Ashkanasy 1998). For example, Orem (1985) defined a health care team as 'an organised group of health care workers who have roles related to meeting the health care needs of a patient or a group of patients' (p 298). Because health care teams focus on the interconnected needs of patients, they coordinate a range of services to meet the specific goals of individual patients (Maple 1987).

Patient-focused production/service teams have traditionally dominated health care environments. These teams included diverse professionals who were all essential in performing complex and diagnostic interventions (Orem 1985). However, there are documented differences in levels of commonality, cooperation and coordination within these teams. Most commonly, these differences are explained across the range of teams described as multidisciplinary, interdisciplinary or transdisciplinary. Maple (1987) distinguished different patterns of communication and performance that represent an evolving trend.

Multidisciplinary teams have historically been more common as they evolved from the traditional medical model, where medical diagnosis and treatment were the primary focus and the physician was the most important provider (Hastings 1997). Each professional in a multidisciplinary team works in parallel, with clear role definitions, specified tasks, hierarchical lines of authority and high levels of professional autonomy (Ivey et al. 1988). Professionals often consult with patients individually and create their own goals and treatment plans (Griffin 1996). As a result, differing priorities between team members may result in inconsistent or contradictory communication to patients.

Interdisciplinary teams are the most common type of team that rehabilitation therapists currently report working in (Mullins et al. 1997). Professionals in an interdisciplinary team meet regularly to coordinate treatment programs to holistically meet patient needs (Maple 1987). Goals are usually set collaboratively and intervention may be conducted jointly (Brandis, Murtagh & Solia 1998). Often, one team member is appointed to coordinate communication between professionals and the patient (Callaly et al. 1998). Interdisciplinary teams are well recognised as beneficial for patients with chronic and complex health problems (Ivey et al. 1988). They most closely reflect the characteristics discussed generally in the literature.

In contrast, transdisciplinary teams are not common in health care, although their preferred use is increasing (Mullins et al. 1997). Participation in transdisciplinary teams often cuts across traditional professional boundaries, as in educational teams that meet the learning needs of children with disabilities. All members contribute, via consensual decision-making, to an individualised plan for the patient, and one or two members are designated as primary agents for intervention (Maple 1987). This level of collaborative practice maximises shared expertise while minimising professional autonomy (Ivey et al. 1988).

Referring back to the categories of teams discussed previously, advice/involvement teams have demonstrated improvements in health care quality and productivity through using

quality circles (Barczak, 1996). While project/development teams are infrequently described in the health care literature, current health management teams could be identified as action/negotiation teams. In these teams, clinicians have focused on delivering quality health care, while administrators concentrated on minimising costs and improving efficiencies, so that together they translated high-quality clinical care into value for money (Wenzel 1995; Adams 1996; Capko 1996). Further, Moss (1996) argued that self-managed work teams are emerging in North America to meet the managed care demands for greater staff utilisation and more streamlined delivery of health care.

Comparison of team categories

Teams appear to be broadly evolving through five stages of production/service, advice/involvement, project/development, action/negotiation and self-management in business environments. In contrast, teams in health care have traditionally focused on production and service in delivering coordinated patient care. There has also been an evolution within production/service health care teams from a multidisciplinary focus towards an interdisciplinary one. This may reflect the way that health care is expanding to incorporate more holistic patient care.

Different categories of teams are becoming more common in health care environments as the health care context changes. It appears that quality improvement initiatives are fostering both advice/involvement and action/negotiation teams. Therefore, it will be important to monitor the changing nature of teamwork in health care, before too many generalisations are made from business to health care environments. Despite the differences in their evolution, there are common characteristics of teams that span both business and health care literature.

Defining a team

Specific definitions of teams abound in the literature. A baseline of definitional consensus is evident across the different types of teams and organisational environments. Katzenbach and Smith (1993, p 45) stated that:

...a team is a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they hold themselves mutually accountable.

Similarly, Brill (1976, p 22) defined teams as:

...a group of people each of whom possess particular expertise; each of whom is responsible for making individual decisions; who together hold a common purpose; who meet together to communicate, collaborate and consolidate knowledge, from which plans are made, actions determined and future decisions influenced.

Across both definitions, six important prerequisites for effective teams are highlighted:

- a small, manageable number of members
- who have the right mix of skills and expertise
- who are all committed to a meaningful purpose
- with specific and achievable performance goals for which they are collectively responsible
- who regularly communicate, solve problems, make decisions and manage conflict
- while adopting a common approach in economic, administrative and social functioning.

Further, Downie and Calman (1994) emphasised that each member must have a distinctive and necessary role within the team. Dunphy and Dick (1985) acknowledged the interdependent nature of team tasks. In addition, Ducanis and Golin (1979) highlighted the need for teams to share a set of norms to guide and limit activity. Hackman (1990) emphasised that teams normally operated within an organisational context.

How teams work

Systems theory has influenced perceptions of teamwork. Teams are described by a three-stage process where they are open systems utilising resources, communicating beyond themselves and producing outputs (Syer & Connolly 1996). Through recognising the common properties of parts and the whole, systems manage complexity (Loxley 1997). Teams, therefore, are dynamic systems that manage organisational change through their own internal and interdependent processes towards a coordinated product. The technical and social aspects of teamwork are also highly interrelated (Pearce & Ravlin 1987). A more detailed description of characteristic conditions for teamwork will be offered in a future article.

The benefits of teams

The task and social benefits of teamwork have been described in the literature. Effective teams achieve better results than a collection of individuals in situations that require multiple skills, experiences and judgements. Teams incorporate and balance a range of specialised knowledge and skills, so that each member concentrates on tasks that challenge his/her level of skill (Horwitz 1970). This ensures the maximum distribution of rare and specialist skills (Brill 1976). The integrated contribution of people with different perspectives and competencies enables teams to be more flexible, innovative, responsive and efficient (Mohrman & Mohrman, 1997). Teams in business environments have been associated with high levels of productivity, quality, customer satisfaction, safety, job satisfaction and organisational commitment, and lower production costs (Kirkman, Tesluk, & Rosen 1999).

Teams in health care environments have demonstrated better continuity and consistency of care through holistic discussion, better planning, enhanced problem-solving and reduced ambiguity between team members (Proctor-Childs, Freeman & Miller 1998). Patients tend to present with several problems that have multiple causes which can rarely be segmented and treated in isolation (Kane 1975). Usually, no one professional group can adequately meet all of the needs of most patients (O'Connor 1994). Therefore, just as patients' health depends on their internal systems integrating well, a health care team acknowledges multiple patient needs and meets these in a coordinated manner (Payne 1982; Loxley 1997). Teams can adopt a holistic view of a patient's health through well-coordinated service delivery. Almost self-evidently, the processes of teamwork can enhance coordination in health care services (Birleson 1998).

Socially, a supportive team climate promotes individual growth and wellbeing (West 1994). Teams can motivate, challenge, reward and support individuals (Katzenbach & Smith 1993). Individual team members can create new ideas and solve problems collaboratively and more effectively through sharing information (Barczak 1996). As they participate more in decision-making, team members demonstrate greater flexibility and a collective commitment to behavioural change (Denison & Sutton 1990). Teams have developed visions and values into consistent action through building on a shared sense of direction and purpose among members. Reciprocally, through the generation of trust and confidence amongst team members, task performance has been enhanced (Katzenbach & Smith 1993). Specifically, in health care teams, members became more aware of their colleagues' skills and were more respectful and appreciative of each other (Kane 1975; Brill 1976). Team members also enhanced their personal learning and commitment to the team and the patients (Birleson 1998).

Barriers to team performance

Despite the plethora of recommendations for effective teamwork, there are still many teams that do not function as well as they could. Barriers to team success are often perceived as difficulties with team structures, processes and in personal choices to work in teams. Issues of general applicability will be highlighted, before the specific challenges for health care teams are discussed.

Mohrman and Mohrman (1997) emphasise the importance of a supportive organisational structure that encourages teamwork. Boundaries between teams, unclear tasks and inappropriate leadership often limit the effectiveness of teams. Further, when individual members come from different units and have different levels of power, they challenge the organisational structure of teams (Payne 1982).

In relation to team processes, West (1994) acknowledged that while teams may be more effective in problem-solving situations, they often took more time to make decisions. Team brainstorming often generated fewer ideas than individual brainstorming. Further, when individual decisions differed from those of the team, those individuals may not always respect the team's decision. While team performance was acknowledged to be

superior to the average member of the team, it was often below that of the most competent individual.

Practically, teamwork is also vulnerable to abuses of personal power, competition and hierarchical considerations (Brill 1976; Firth-Cozens 1998). Teams often engender a social pressure on individual members to conform, such that they feel obliged to agree with the group opinion, without sufficient external information or communication. Alternatively, some individuals work less hard when they know their efforts are combined with others' (West 1994). Further, the extent to which individuals conform to team norms is influenced by professional affiliation and perceived status (Kane 1975).

Teamwork also raises some fundamental human dilemmas. Many people have an inherent preference between working with others and working alone. While a diversity of skills and perspectives is needed to manage complex patient needs, many people are more comfortable mixing with those who are similar to themselves (Firth-Cozens 1998). Raines (1988) suggests that individuals hold different value systems and preferences regarding teamwork, and these may be in potential conflict with others or with the team's goals and values. Members who have hidden agendas and secondary goals may engender further interpersonal conflict. In health care environments, team-members need to have resolved their personal needs for dominance and autonomy in intervention, as patients are often treated by other professionals and treatment issues discussed openly in team meetings (Brill 1976).

Challenges for health care teams

In addition to the obstacles described above, health care teams face other challenges in their organisational context, team structures and in relation to issues of professionalisation.

Horwitz (1970) identified the challenge for health care organisations to define relationships between teams and the executive, and between team leaders and other staff. Teams do not fit neatly into many health care hierarchies, because teams include people of different levels of power and status. Health care bureaucracies also limit the flexibility of teams in responding to organisational change (Firth-Cozens 1998). Problematic administrative designs commonly exist where team members have dual or inconsistent accountability. A matrix management structure is widely used, where workers belong to a hierarchical professional structure and are simultaneously operationally accountable within specialised clinical teams comprising many different professionals (Brandis, Murtagh & Solia 1998). Other systems of portfolio management also exist where team leaders are responsible for additional projects (Birleson 1998). In some settings, health care professionals caring for the same group of patients may be employed by different organisations and work to different standards (Headrick, Wilcock & Batalden 1998). Problems with these structures arise when there are blurred boundaries, uncertain power relationships and individuals have to reconcile the differences.

In addition, there are often individualised and discipline-specific reward, supervision and educational structures (Kane 1975; Payne 1982; Maple 1987). Traditionally, in most health care organisations the medical profession is dominant and other team-members may be overly influenced by the medical subculture (Horwitz 1970). For example, Hearnshaw et al. (1998) reported that in many health care teams doctors were responsible for most of the decision-making and they often discounted others' views as being unimportant and unrepresentative.

Health care teams are very dynamic, and they often need to renegotiate their structures in response to internal and external change. In response, teams often adopt a continuing process of role clarification and redefinition as diverse groups of colleagues match personal characteristics with written position specifications. What is expected and necessary for a particular professional in one health care organisation may be questioned or forbidden in another, similar setting (Horwitz 1970). The role of patients and their families also needs careful consideration. With the rise of consumer advocacy there is ongoing debate about the inclusion of patients and their families within teams. For example, in early intervention teams that span health and educational environments, Maple (1987) advocates for parents to be equal and contributing members. This increases the sources for potential conflict, such that conflict may occur between any combination of the organisation, the team, team members, the patient and their family.

Doctors have traditionally dominated health care with their specialised expertise. Currently doctors are being challenged to be more flexible in their working practices to enhance patient care (Abelson, Maxwell & Maxwell 1997). Over the last 40 years, doctors have progressively worked with other health care professionals in a more egalitarian and interdependent manner (Cott 1997). Yet, as other professionals work more with doctors, their cumulative attainment of expertise risks fragmenting medical knowledge (Horwitz 1970).

Generally, professional groups within health care have very different cultures from doctors. All professional groups differ in their education, status, language and theoretical frameworks. Specifically, there are differences in professionals' beliefs, expectations and accountability for teamwork. Each profession identifies their unique and distinctive knowledge and skills over which they maintain autonomy and control. Professional associations and schools guard and protect this expertise at the expense of both internal and external competition (Maple 1987; Loxley 1997). Specifically, Qualls and Czirr (1988) suggest that different models of professional activity occur along continuums of assessment rationale, intervention priorities, levels of responsibility and the pace of action. Health professionals may also be influenced by inaccurate stereotypes of their colleagues' skills and responsibilities (Griffin 1996). Ignorance, competition and jealousy can reinforce stereotypes, which may further erode professionals' respect for and understanding of each other. Within this environment, conflict and negotiation over issues of role definition restricts collaboration and often reinforces professional boundaries (Ivey et al. 1988). Further, when members hold different views, they do not always listen to and accept the opinions of other team-members, cooperate or show

commitment to the team's activities (Hearnshaw et al. 1998). With the introduction of general managers to health care settings, many clinical professionals have experienced tensions between corporate management priorities and traditional clinical freedom and autonomy (Headrick, Wilcock & Batalden 1998).

There may also be negative impacts on patients when their needs are subsumed by the internal politics of professional power (Kane 1975). Not only can individual responsibility for the patient be diffused among the health care professionals in the team, but patients may also receive conflicting messages from team members when they are least capable of dealing with ambiguity. Conflict and confusion can be exacerbated by logistical problems of scheduling, record-keeping and physical proximity.

Summary

Despite the many inherent difficulties of teamwork, most health care professionals have a personal desire to learn and they value meeting the needs of their patients (Headrick, Wilcock & Batalden 1998). However, it appears that effective teamwork in health care organisations is assumed and expected, often without sufficient consideration for the types of team required and the organisational context in which they function. There is a general transition through categories of teams in business environments in response to participative management structures, work specialisation and an enhanced customer focus. Teams have become important tools in promoting and managing organisational change. While most research has been conducted in business settings, there is a need to investigate teamwork further in health environments.

As yet, there is little documentation of the changing nature of teamwork in health care. Currently, it appears that the traditional patient-focused production/service teams are moving from a multidisciplinary to an interdisciplinary focus. Health care teams are also being expected to perform quality and management tasks in addition to delivering coordinated patient care. Perhaps optimal health care teams may be more consistent with advice/involvement and action/negotiation teams. The business literature may be able to be generalised to health care if the significant differences between both environments are kept in focus.

There appear to be several opportunistic strategies to promote effective teamwork. Although professional groups perceive different benefits and requirements of teamwork, it is important for individuals to openly discuss these differences. In this way, complementary values and attitudes can be identified as the basis for interdependence (Loxley 1997). Further, to prevent the institutionalisation of professional differences, team members need to focus on patient needs. When individuals collaborate around patient needs they can generate a shared perception of what is required of the team and how best the team can achieve it. Specifically, clinical pathways clarify how team members all contribute to meeting patient needs in clear and consistent patterns of work. Finally, individuals become more committed and responsible when they understand and experience the benefits of working in teams. In this way, continuums

of overlapping interests between professionals should continually be recognised and discussed to focus negotiation around patient needs (Kane 1975).

Once the historical and organisational context for teamwork is recognised, the characteristics and outcomes of effective teams complete a holistic description of teamwork in health care. Ultimately, a conceptual framework for understanding teamwork in contemporary health care is needed to support and educate health care professionals about teamwork. Then effective teams will be able to consistently promote quality health care for all patients.

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