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LEVELS OF INTERACTION -
GROUP, TEAM, AND ORGANIZATION

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Health teams are complicated and frequently feel complicated to team members. The concepts and practice of team work often are difficult to grasp and even more difficult to achieve. Indeed, team members frequently complain about the frustration, fatigue, irritation, energy drain and burn out that seem to attend the team experience.

Effective collaboration between health providers has been a necessary condition of patient care for many years. Effective team practice already exists in many areas of specialized medical care, such as the hospital operating room, where rules for working together are highly developed, and in rehabilitation centers and special clinics for children, where multiple skills are required. Indeed, wherever the clinical task requires a group of individuals to work collaboratively and interdependently--this constitutes a team, even though the individuals involved may not envisage themselves as such.

At the same time, observation of health care teams in primary care has indicated an enormous complexity of relationships and levels of interaction which seems related to their broad egalitarian mission, as well as to lack of a commonly accepted theory of health team development and function. In its place, one finds elements of theory derived from general systems, organizational psychology, small groups, group dynamics and, more recently, communication, each of which appears to fit only a limited aspect of the team phenomenon.

The problem may also derive from the fact that health teams seem to mean different things to different people, as reflected in their diverse motivations for participating. Indeed, joining or participating on a primary care team may represent new or special ways of 1) learning and interacting with others; 2) working and performing tasks with others; and 3) delivering care or creating institutional or systems change. It is of interest that these three motivations fit in with the

schema of group, team, and organization implied by the title of the paper. The problem is that effective teamwork in health care involves all three levels, and, unless prospective team members are prepared to deal with all three, difficulties are sure to arise. Indeed, the uniqueness of teams may lie in the acknowledged need to attend equally to all three areas if personal satisfaction, development and survival are to be achieved.

Team as Group

By definition a team is a group, in that teamwork necessarily involves more than one person. Indeed, one of the major heritages of modern team development comes from our knowledge and experience with group dynamics and communication theory. The problem, as Sarason (1972) has indicated, is that teams frequently form around an idealistic, charismatic leader, who excites the interest of and recruits others to the end of achieving his mission, only to find that as the initial excitement over the project begins to fade away, inevitable differences arise as the group begins to focus on specific tasks. Some key concerns from a small group point of view, then, would be how the team handles its relationship with the "leader" - usually the administrative head of the team; how sexuality of team members is acknowledged and dealt with; the kinds and clarity of decision-making processes used and the attention paid to internal team maintenance.

There are many similarities between teams and groups. First, teams, like groups, appear to go through certain predictable stages of development. The familiar "form-storm-norm-conform-" phenomenon has been described and refined by a number of workers, but, in essence, points out that teams and groups have a life of their own and that members must recognize and participate in this process.

A second similarity between groups and teams deals with the issue of leadership and dependency. Many of the same interpersonal issues around what kind of person assumes or is accorded a leadership role, and, at what time in the team's life and development, apply to both phenomena. The teams we have observed at times exhibit behavior characteristic of the dependency groups described by Bion (1959). In such a group, the "leader" is looked to as the one who can solve the group's

problems. As the leader or others try to fulfill these "needs" they will be unsuccessful, because the group has unreal expectations.

Finally, as in groups, the issue of personality characteristics and differences appears to play a major role in team interaction, although, as Rubin, et al. (1975), Sarason (1972) and others have pointed out, interpersonal conflict on teams frequently is a reflection of unclear goals and roles and dysfunctional decision-making procedures. Recently, several workers have become interested in the issue of the personality types (Myers, 1976) and managerial styles (Reddin, 1965). Baldwin and Baldwin (1979) report that one of their teams showed a high preponderance of persons with the managerial style of Developer, with the supporting style being that of Missionary. Such persons may be extremely effective at an interpersonal or relationship level, but may exhibit a low task orientation. Royer (1976) reports the use of the Myers-Briggs Type Indicator (MBTI) to select members of family practice residency teams. It is his observation that S (sensing) types may have difficulties in working with others in this type of relationship and may be the first to drop out. It is also his impression that persons who differ by more than two MBTI styles or dimensions may have difficulty working with each other.

Technologies or skills identified as useful for being an effective member of a team at the group level, then, would be 1) an awareness of small group and communications processes and theory; 2) the acquisition of interpersonal and group development skills; 3) the use of communications exercises to develop such skills; and 4) an awareness and appreciation of sameness-difference issues.

Team as Team

The major difference between teams and groups is the orientation to task in the former, which inevitably introduces the dimensions of time and external demand. Teams are characterized by deadlines, by work loads, by the need for predictable output, by the need for making decisions and establishing priorities, and by having to satisfy external constituencies, such as students, patients and administration. A task group usually describes its processes around issues such as decision-making, leadership, role negotiation, interpersonal relationships, and conflict resolution. In

addition, for health care teams, the task (health care) can be analyzed in terms of efficiency, quality of care, client attitudes, and other outcome variables used to assess health care. A good analogy may be that of the family, which not only exhibits interpersonal and group characteristics and relationships, but also must assume certain clearly defined tasks and responsibilities if it is to survive and meet the needs of its members. Indeed, the family also functions as group, team, and organization, and frequently has difficulty attending to all of these levels simultaneously. As with family and marital quarrels, the team cannot always "work it through" on the spot, but may have to go to work and delay such negotiations until there is time.

The major theories relevant to task accomplishment appear to come from general systems and organizational development, and are borrowed from learnings about industry. Workers in this field have developed a systematic approach to organizational and team development. Once again, the issue of stages or processes appears relevant, as Rubin, et al. (1975) call attention to the need for establishing goals, roles, and procedures for decision making and conflict resolution. Eichhorn's (1974) identification of Subactualization, Confrontation and Actualization stages on teams calls attention to the importance and value of differentiation in the growth and development of teams, as opposed to the more commonly discussed need for coming together in the work situation.

Task is different in that it can be evaluated quantitatively. It deals with issues of efficiency, effectiveness, cost and quality. Concepts such as input, throughput, and output have relevance, whereas at a group or interpersonal level, these issues seem less important. The specific technologies which appear to have evolved for resolving the issue of team "work" are outlined by Rubin and his co-authors (1975). They stress a clear recognition that there are specific processes and procedures required for team development which cannot be ignored. Instead of stages, they pose a sequence of questions or issues which the team must resolve if it is to succeed. Techniques such as the "Team Temperature Scale" developed by Rubin and adapted by the Universities of Nevada and Hawaii, the Action Item Log developed by NASA and adapted for use by the Nevada team appear to be useful ways of maintaining task orientation in the midst of group needs and pressures.

Team as Organization

Health teams also live in an environment which includes patients, students, administrators and professional reference groups, as well as community agencies and institutions. Thus, at an organizational level, there are clearly external as well as internal dimensions to the life of the team. Teams, therefore, must decide when and how much of their resources and time to spend dealing with these dimensions.

Organizations are constantly interacting with their environment, trying to gain support or adapt to changes (Katz and Kahn, 1966). For health teams, there are a number of structures in the environment with which they interface and from which they try to secure resources. Baldwin, et al. (1976) believe that health teams can be meaningfully conceptualized as systems with boundaries (von Bertalanffy, 1962; Beckhard, 1974). They find that most health teams fail to manage or control the permeability of their boundaries or interfaces and are either drowned by too much input or depleted by too much output.

By examining the quality of the relationships between the team and these external systems one presumably can identify problem areas. Imbalance in the interchange can serve to identify energy loss and may have longterm implications for team health and survival. This is often a difficult task and may be distorted by the methods used to evaluate these relationships. However, such an analysis is vital to team survival and is probably best done with the help of an outside consultant. Some of the questions which appear relevant to this inquiry include:

1. With what other systems does the team interface?
2. What does the team need from these other systems?
3. What do the systems require from the team?
4. How does the team get what it needs?
5. How are the boundaries or interfaces tended? Who negotiates with whom and how?
6. How are these relationships evaluated?

Individuals endowed with boundary tending roles may have considerable influence over maintaining boundary permeability. Therefore, the selection of these persons and the process by which it takes place is an important aspect of team processing.

A special problem may arise in the relationship of the team to its own parent institution or organization. Teams are potential change agents. Merely by existing, they call into question many established procedures and relationships at their parent institutions. Thus, the existence of a "leaderless" team (usually a perception rather than a fact), within a hierarchically organized university or hospital, usually causes problems for responsible administrators. Questions arise, such as: Who is empowered to speak or make decisions for the team? Who is responsible? Who gets the credit or blame? Indeed, teams are occasionally accused of lack of accountability and of hiding behind group anonymity.

Recognized techniques or strategies for dealing with these issues include many of those pioneered in industry: use of an outside consultant, knowledge of organizational development and applied behavior techniques, and regular attention to internal and external maintenance needs.

Discussion

Any health team is probably operating at all three "levels" at any moment in time. That is, there are group issues to be resolved, decisions to be made about roles and tasks, and negotiations to be conducted with administration. Furthermore, there may well be a crisis brewing in one area, e.g. a deadline for a grant proposal, when the team's energy is focused on another area, e.g. doctor-nurse conflict. Is it really any surprise that team members feel the way they do at times?

Given the three levels on which health teams appear to operate, one can pose a fascinating question. As a training vehicle, what are the purposes of student health teams? Should the main purpose be to teach "team skills" in order to prepare professionals for teamwork in the future? Should the purpose be an exploration of alternate approaches to health care or to evaluate team vs. traditional methods of delivery? Should the purpose be skill development? Or, is the thought

accurate that teams are basically subversive of the present health care delivery system? Somehow, by legitimizing the examination of group process, task procedures, and organizational development, the health team may show the rest of us where our weaknesses may be as providers or parts of the health system.

There appears to be no reason why student health teams should not experience some or all of the above team issues as part of their learning experiences. A health team experience has great potential for teaching participants a variety of skills and knowledge applicable to the future practice of comprehensive and collaborative care in the community. In so far as people can become sensitized to these issues and begin to explore them, we believe they will be more effective care providers whatever their discipline or setting.

Conclusion

The observations reported in this paper are not new or unique. Indeed, they are so simple in concept that one is tempted merely to record the title of the paper and leave the rest to the imagination and experience of veteran team members. At the same time, it appears useful to identify these three levels of interaction, which, in our experience, occur on all health care teams, and to indicate both the theoretical frameworks and specific skills and technologies required for managing them.

The authors respectfully suggest that teams and team members need to pay more attention to the inherent complexity of the health team phenomenon, and consciously establish priorities and develop resources for meeting these challenges. While there is no formula for this process (nor are we aware of any team which has done it "perfectly"), it would appear that the very cause of the complexity, i.e. the diversity of team members' goals and tasks, also holds some promise for its solution. Indeed, it is out of the healthy interaction of diverse views that health care teams can offer significant contributions, not only to the accomplishment of improved care, but also to the advancement of the knowledge, theory and practice of collaborative human endeavor.

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